Interpersonal Psychotherapy for late life depression in general practice

van Schaik, D.J.F.

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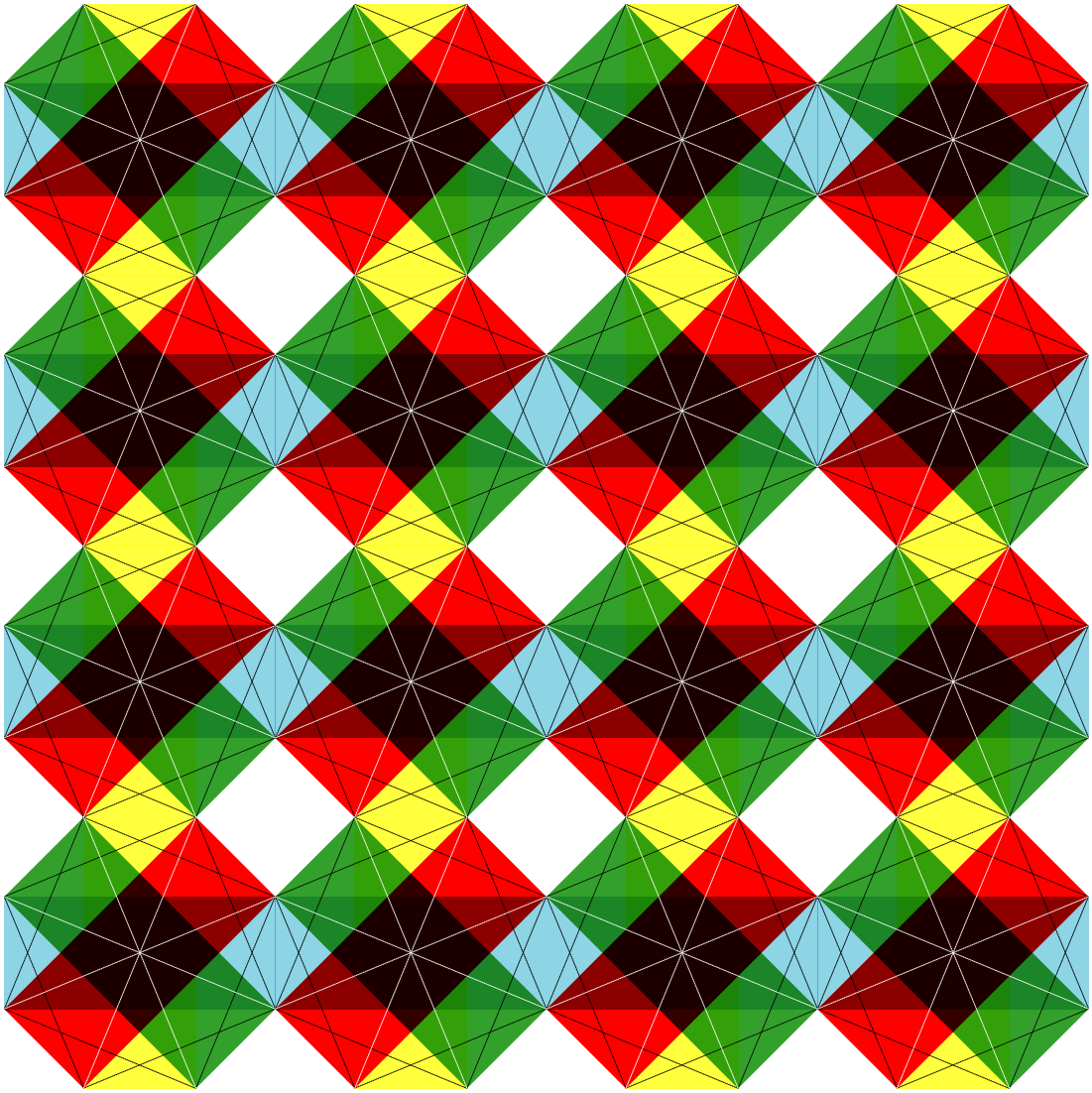

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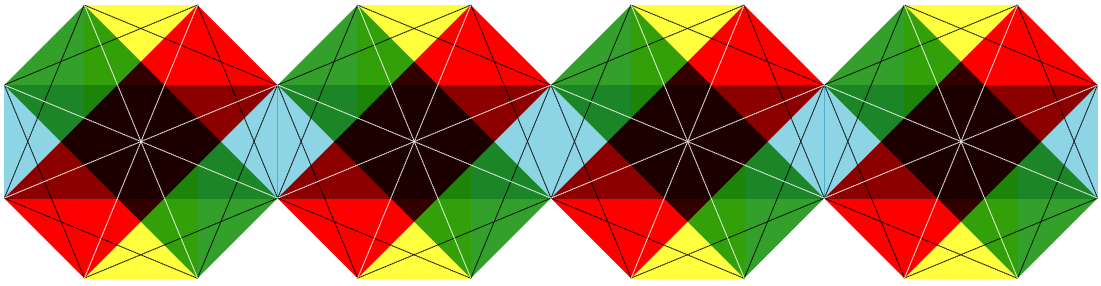
Anneke van Schaik



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Interpersonal Psychotherapy for late life depression in general practice

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CHAPTER 1

Introduction

1.1 The health care problem addressed in this thesis

Of the older patients who visit their general practitioner 5-10% has a depressive disorder (Lyness et al., 1999; Schulberg et al., 1998). Depression causes suffering and is associated with serious disability, reduced quality of life and general functioning. The prognosis of depression in elderly community and primary care populations is poor. It was found that only 12% of older primary care patients had recovered after six months (Schulberg et al., 1998), and in a meta-analysis it was estimated that 33% had recovered after two years (Cole et al., 1999). In a prospective study in the community, 23% of the patients had recovered after six years. (Beekman et al., 2002). If depression in the elderly remains untreated, it increases mortality from co-morbid medical conditions or suicide, and increases service utilisation and demands on caregivers (Charney et al., 2003; Penninx et al., 2000). Therefore, delivering efficacious treatments is of major importance for this group of patients.

Although more than 80% of older depressed persons regularly contact their general practitioner (Beekman et al., 1997), many of them do not receive specific depression care, despite the existence of efficacious treatment options such as treatment with antidepressants or psychotherapy (Baldwin et al., 2003).

An important barrier to adequate care is that depression is often not diagnosed. Especially in elderly patients, neither the patient and his family, nor the general practitioner may recognise or acknowledge the symptoms of depression. In older patients, depressed mood is often less prominent than other depressive symptoms such as loss of appetite, sleeplessness, anergia, and loss of interest and enjoyment of the normal pursuits of life. Additionally, older patients frequently have physical illnesses and/or social and economic problems. The depressive symptoms may be interpreted as a "normal" consequence of these problems (Lebowitz et al., 1997).

Case vignette

Mr. Jansen (66) and his wife visit the general practioner (GP). During the last year Mr. J. has not been feeling well: he is tired, has sleeping problems, has been losing weight, and has stopped most of his social activities. His wife advised him many times to go to see the doctor, but he did not want to. Now, she has forced him to come with her. Mrs. J. thinks that maybe he has a physical disease that explains his lack of energy and weight loss, and she asks for further examination. The general practitioner explores the symptoms, does orienting physical examination, and decides to do several blood tests to check for possible abnormalities. They make a new appointment for the following week to

discuss the findings. During this second appointment the GP states that no signs of a physical disease were detected. Mrs.J. proposes further examination in a specialist health centre. However, the general practitioner considers the probability that Mr. J. suffers from depression. He explores depressive symptoms, alcohol use, and psychosocial circumstances. He concludes that the complaints might very well be explained by a depressive disorder. The depression may be related to Mr. J.'s recent retirement. Possibly, alcohol abuse also plays a role, as alcohol induces depression.
The GP discusses the depression and its possible association with recent life changes and alcohol use. This interpretation of the symptoms makes Mr. J. and his wife uncomfortable. As they have already spent far more than 10 minutes at this session, they are advised to think about what has been discussed, and are given written information about depression. A new appointment is made. A week later, Mrs. J. comes alone. Again, it is suggested that depression is the most probable explanation for the symptoms. Mrs. J. now agrees. She tells the GP that there were indeed some problems after her husband retired. She got nervous of him being around all the time, commenting on her housework. Her husband has had difficulty finding new activities, and she thinks he misses his work. He has started drinking more alcohol. Yet, they do not talk about this, they were never good at discussing "emotional things". The possible treatment options are discussed: antidepressant medication as well as psychotherapy may be effective. Mrs. J. will talk to her husband about this and try to motivate him for one of these options.

In this case vignette several aspects of diagnosing depression are illustrated: First, physical symptoms were presented as the main problem. These had to be explored and a physical disease ruled out. Second, the "shift" from a physical complaint to a psychological/psychiatric interpretation had to be made. It took several sessions before at least the patient's wife accepted the labelling of depression. Third, the patient will have to be motivated and well informed, before he will accept and comply with depression treatment.

Even when depression is diagnosed and a treatment plan is proposed, there are still barriers that may cause insufficient depression treatment: physician related barriers (e.g. inadequate dosing of antidepressants and insufficient monitoring of symptoms and side-effects), patient-related barriers (e.g. non-adherence to treatment, refusing referral because of fear of stigma), and system-related barriers (e.g. psychotherapy not available within primary care) (Wetherell & Unutzer, 2003; Alexopoulos, 2001).

1.2 Depression treatment guidelines for general practice

For classification of mental diseases the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 2000) is most frequently used. The DSM-IV criteria for major depressive disorder are presented in Table 1.1. The mood module of the PRIMary care Evaluation of Mental Disorders (PRIME-MD; Spitzer et al., 1994), which is based on DSM-IV, is often used in primary care research (Table 1.2).

Table 1.1 Diagnosis of major depressive disorder (DSM-IV-criteria)

Major Depressive Episode

A) Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).
2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
4) Insomnia or hypersomnia nearly every day.
5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6) Fatigue or loss of energy nearly every day.
7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal

ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B) The symptoms do not meet criteria for a Mixed Episode.

C) The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D) The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E) The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterised by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Diagnostic Criteria for Major Depressive Disorder

A. Presence of Major Depressive Episode.
B. The Major Depressive Disorder is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode.

Table 1.2 PRIME-MD mood module

Major Depression

For the last 2 weeks, have you had any of the following problems nearly every day?

1. Trouble falling or staying asleep, or sleeping too much?	Yes	No
2. Feeling tired or having little energy?	Yes	No
3. Poor appetite or overeating?	Yes	No
4. Little interest or pleasure in doing things?	Yes	No
5. Feeling down, depressed, or hopeless?	Yes	No
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down?	Yes	No
7. Trouble concentrating on things, such as reading the newspaper or watching television?	Yes	No
8. Being so fidgety or restless that you were moving around a lot more than usual? If No: What about the opposite – moving or speaking so slowly that other people could have noticed? Count as Yes if Yes to either question, or if psychomotor agitation or retardation observed during interview.	Yes	No
9. In the last 2 weeks, have you had thoughts that you would be better off dead or of hurting yourself in some way? If Yes: Tell me about it.	Yes	No
10. Are answers to five or more of #1 to #9 (one of which is #4 or #5)?	**Yes**	No

Major
Depressive
Disorder

In the Netherlands, the majority of depressed patients are treated in general practice (Verhaak, 1993). The Dutch College of General Practitioners (NHG) has developed a depression treatment guideline (Van Marwijk et al, 1994), which has recently been revised (Van Marwijk et al., 2003). After depression is diagnosed, the first steps in a depression treatment plan consist of exploring the existence of potential co-morbid disorders (and treating them), giving psychoeducation about depression and giving lifestyle advices. If the depression has lasted for less than three months, no other specific interventions are advised ("watchful waiting"), because in the general population 50% of younger adults recover spontaneously within three months (Spijker et al., 2002). When patients still have symptoms after three months, antidepressant drug treatment and/or short-term psychotherapy are indicated. Usually, depression treatment consists of antidepressant drug treatment, because drug treatment fits well into the usual practice of the GP and referral is not necessary.

The question is whether these guidelines, which are mainly based on research in younger adults, should be applied to older patients. For example, relatively little is known about the effectiveness of the main treatment options (antidepressants and some forms of psychotherapy) for older depressed patients in general practice. In a review on treatments for late life depression in primary care, Freudenstein (2001) found no studies of psychological treatment, nor any high quality studies of drug treatment. Furthermore, it may be doubted whether the watchful waiting time period of three months is adequate for older patients, given the poor prognosis of untreated depression in the elderly. Moreover, the need for easily accessible psychotherapy for older depressed patients should probably be more emphasized, as these patients are at risk from side effects of antidepressants and from drug interactions. They are also more reluctant to be referred (Bartels et al., 2004).

1.3 Intervention to improve depression care for elderly patients in general practice

The starting point of our research project was to contribute to improved depression care for older patients in general practice. We knew that depression in older primary care patients is a serious health care problem and that the efficacy of antidepressant drugs and some forms of psychotherapy (e.g., Interpersonal Psychotherapy, IPT) for elderly secondary care patients has been proven (Reynolds, et al., 1999; Wilson et al., 2001). However, these studies were conducted under strictly controlled conditions: only motivated patients with no (somatic) co-morbidity were included, the selected therapists and doctors

were highly skilled, and the treatment effect was based on a comparison with placebo. No studies were available on the effectiveness of these interventions for older patients in "normal life" general practice. We also knew that several barriers obstructed the application of these evidence-based treatments to general practice.

Representatives of both the Departments of General Practice and Psychiatry at our research institute (Institute for Research in Extramural Medicine (EMGO), VU University Medical Centre, Amsterdam) joined the project group. We chose to focus on two barriers to optimal depression treatment: the insufficient detection and acknowledgment of major depression, and the absence of evidence based psychotherapy in most general practices. By removing these barriers we would be able to study the effectiveness of the psychotherapy intervention compared with usual GP care for older depressed patients in general practice.

For detecting depression we used a screening procedure that identified patients with major depressive disorder according to DSM-IV. This strategy, screening for depression, is somewhat contradictory to the usual approach of GPs: the problem as presented by the patient is usually the basis for further action. In addition, GPs are less focused at classification of depression or other mental disorders than psychiatrists, because psychic problems in primary care patients are often diffuse and less pronounced than in secondary care. Yet, because we wanted to target underdiagnosis of depression and we assumed that evidence based psychotherapy would be helpful for all detected patients with major depressive disorder, we considered screening a suitable approach.

As evidence based psychotherapy we chose interpersonal psychotherapy (IPT) to be delivered by specialist mental health workers within general practice. We had several reasons for choosing this method:

- At the time we started our project, IPT and Cognitive Behavioural Therapy (CBT), were mentioned in most depression treatment guidelines as evidence based psychotherapies. We chose IPT, because it had not only proven to be effective in older patients (Reynolds et al., 1999) and in adult primary care patients (Schulberg et al., 1996), but it can also be learnt relatively easily by therapists with different therapeutic backgrounds. It is time-limited, and the treatment protocol is available in a manual (Weissman et al., 2000). At the beginning of the therapy the therapist discusses and labels the depressive symptoms as a disorder that can be treated. He/she emphasizes the interaction between depressive symptoms and social relationships. Together, the therapist and patient choose a specific psychosocial problem to work through

and solve. The therapist has an active role in educating the patient about depression and in supporting the improvement of relationships and social functioning. The IPT format fits well to the problems of older patients (Miller et al., 1997).
- Therapists instead of GPs themselves delivered the psychotherapy, because providing IPT is very time-consuming and not part of GPs vocational background. Therefore, training of GPs to carry out psychotherapy was not considered to be feasible.
- The IPT was to be delivered within the general practice, because in the Netherlands, GPs are the gatekeepers of the health system. The high numbers of elderly depressed people that visit their GP (>80% yearly) in combination with the high costs and the negative stigma attached to formal psychiatric treatment, supported the idea that treatment for late life depression should be centred within primary care.
- In recent years, the transfer of expertise from specialised care settings to the primary care setting has had priority in Dutch health policy. The development and implementation of a transmural psychotherapeutic intervention, aimed to serve large numbers of older depressed patients in primary care, was therefore highly relevant for public health. If it could be demonstrated that it is feasible and effective to deliver evidence based psychotherapy transmurally, this would prove that 'expertise transfer' and collaboration between primary and secondary care settings is an effective approach in daily practice, and that organisational changes, necessary to implement this intervention, should be supported.

1.4 Preparation of the randomised controlled trial

We sent a letter, describing the project and asking for participation, to key representatives of specialist mental health centres and general practices in and around Amsterdam. About one week later we contacted them by telephone. Four Specialist Mental Health Centres and 12 (mostly group) general practices agreed to participate.

Our research assistants carried out the patient screening procedure. They visited the practices every month to collect the names and addresses of the patients aged 55 years or older who had recently visited the GP. To these patients we sent a letter on behalf of their GP, in which they were asked to complete and return the screening questionnaire to our Research Institute. By performing the screening procedure in this way, we avoided probable bias from patient selection by the GP.

Although many therapists were interested in IPT, none of them were trained in this method. Therefore, we had one of the project members (AvS) trained as an IPT supervisor and trainer by Marc Blom and Kosse Jonker (Dutch Centre for IPT, The Hague). Then, we had to develop training materials and a training course to prepare therapists for participation in the project. We wrote an IPT manual in Dutch, integrating the possible adaptations for elderly patients described in the IPT manual (Weissman et al., 2000). For use in primary care, we reduced the usual number of 14 IPT sessions to 10. In the mental health teams for older patients, relatively few psychotherapists were available. Therefore, we also recruited experienced psychiatric nurses, as it was demonstrated in other projects that psychiatric nurses can carry out manual based psychotherapies (Mossey et al., 1996; Mynors-Wallis, et al., 1997). This approach has several advantages with regard to the implementation potential of the intervention. Not only is the intervention probably more cost-effective when delivered by nurses, there is also a tendency in the Netherlands that GPs will be more and more supported by psychiatric nurses in the treatment of mental health problems. In this way, IPT may be easily integrated in the primary care tasks of these nurses.

1.5 Aims and structure of the thesis

The primary aim of this thesis was to study the feasibility and effectiveness of transmural Interpersonal Psychotherapy (IPT) for late life depression in general practice. We conducted a randomised clinical trial and recorded, analysed and described feasibility and effectiveness data. Afterwards, we studied predictors of outcome in our research population and in patients of a parallel study on the effectiveness of guideline driven drug treatment for late life depression in general practice (West Friesland Study, Bijl et al., 2003). Furthermore, we reviewed the international literature to place our findings in a broader perspective. Theoretically, literature reviews should be completed before the beginning of a research project. However had we limited ourselves to the literature that appeared before the start of this project, the results would have been meagre and outdated. Therefore we also added more recent publications. We explored the effectiveness and cost-effectiveness of psychotherapy interventions for depressive disorder in primary care, and we summarized findings about patients' preferences regarding depression treatment in primary care. The thesis is structured as follows:

In Chapter 2 the systematic review of the effectiveness of psychotherapy and counselling for depressive disorder in primary care is described. Because we knew that very little was known about the effectiveness of these interven-

tions in older primary care patients, we explored the results in younger adults to get an indication about the effectiveness we could expect in our trial.

In Chapter 3 the systematic review of the cost-effectiveness of psychotherapy interventions for depression in general practice is presented. With regard to the feasibility of implementing psychotherapy in general practice, we thought it important to know how the costs relate to usual GP care or to antidepressant drug treatment.

In Chapter 4 patients' preferences in the treatment of depressive disorder in general practice are outlined. In the light of our project, we were especially interested in what patients think about psychotherapy compared with antidepressant drug treatment.

Chapter 5 concerns the feasibility of introducing IPT in general practice. In this study we used a descriptive approach, recording feasibility from the perspective of the patients, the GPs and the therapists.

Chapter 6 presents the results of the effectiveness trial comparing IPT with usual GP care.

Chapter 7 reports on a predictor study of (treatment) outcome in the patients of the IPT study and those of the parallel West Friesland Study.

In Chapter 8 the results are summarized and in the general discussion comments are given and limitations discussed.

Chapter 9 describes the summary in Dutch.

The Dutch IPT manual for late life depression in general practice is added in the APPENDIX.

CHAPTER 2

The effectiveness of psychotherapy for depressive disorder in primary care: a systematic review

Van Schaik DJF, Van Marwijk HWJ, van der Windt DAWM, Beekman ATF, De Haan M, and Van Dyck R. (2002). Tijdschrift Voor Psychiatrie, 44(9): 609-619.

ABSTRACT

Background Psychotherapy may be an alternative to drug treatment for depressive disorder in primary care.

Aim To explore what is known about the effectiveness of psychotherapy for depressive disorder in primary care.

Method Systematic review. Randomised controlled trials were selected in which the effectiveness of psychotherapy was studied in primary care patients with depressive disorder.

Results Ten studies met the selection criteria. Overall (based upon five studies), psychotherapy applied in a primary care setting was slightly more effective than usual care by a primary care physician for patients with depressive disorder. In seven studies, psychotherapy was as effective as antidepressant treatment. In one study, psychotherapy was more effective than placebo medication for patients with major depression. In patients with minor depression or dysthymia there was no difference compared to placebo (two studies).

Conclusion Psychotherapy is a good alternative to drug treatment in adult primary care patients with depressive disorder.

2.1 Introduction

According to the World Health Report 2001 (WHO, 2001), depression is the first leading cause of disability worldwide. Depression is consistently associated with increased utilisation of health services and with a substantial burden of disability (Simon 2002a). In the Netherlands, it has been found that the one-year prevalence of depression among adult patients visiting their general practitioner is 14.3% (Ormel & Tiemens, 1997). Although in the general population 50% of the patients with depression recovered within three months, 20% still had depression after two years. This underlines the necessity of diagnosing and treating those at risk (Spijker et al., 2002). The majority of the depressed patients are being treated in primary care settings (Verhaak, 1993). In secondary care, specific depression treatments have been developed and studied. Some forms of psychotherapy and antidepressant drug treatment have proven to be efficacious in secondary care populations. However, relatively little is known about the effectiveness of these interventions in primary care populations.

In 1994 The Dutch College of General Practitioners (NHG) developed a depression treatment guideline (Van Marwijk et al, 1994). This guideline focussed on how to deliver antidepressant drug treatment optimally, but relatively little attention was paid to psychotherapy. This seems to be an omission as there are patients who are not motivated for drug treatment or who do not tolerate it. Furthermore, patients may be reluctant to be referred to mental health care. For these patients, delivering psychotherapy within general practice may lower the barrier to adequate care.

The aim of this paper was to explore the effectiveness of psychotherapy and counselling for depressive disorder in primary care. We performed a systematic review of the literature. Our research question was: how effective are psychotherapy interventions in the treatment of depressive disorder in general practice compared with a) usual general practitioners care b) antidepressant drug treatment, and c) placebo medication?

2.2 Methods

2.2.1 Search strategy and study selection

A computer-assisted search of Medline, Psychinfo, the Cochrane Library and EMBASE was carried out. Search terms and keywords used were: "depressive disorder", "depression ", "dysthymic disorder", "primary health care", "general practice", "family practice", "psychotherapy", "counselling", "problem solving", "interpersonal psychotherapy", "outcome," "effectiveness", "randomised controlled trial", "clinical trial". References given in relevant identified publications

and reviews were also screened.

Studies to be included were selected by screening titles and abstracts of all publications downloaded from the electronic databases. Inclusion criteria were: (a) the subjects of study were adults or elderly patients with depressive disorder or dysthymia, (b) the study design was a randomised clinical trial, (c) the setting of the study was primary care, (d) the intervention under study was psychotherapy or counselling delivered as a mono therapy, (e) data were presented in a way that quantitative comparison with other studies was possible.

2.2.2 Methodological quality assessment and data abstraction

The methodological quality of the studies was assessed independently by two reviewers (AvS and HvM) using the validity items of the Amsterdam-Maastricht-consensus questionnaire (Van Tulder et al., 1997). This questionnaire aims to assess the internal validity of randomised controlled trials. Disagreements between the reviewers were solved by consensus.

Relevant data were extracted and summarised. In our analysis, we used the results of the assessments directly post-treatment. When several depression measures were used in one study, we extracted the results of the measure that was most frequently used in the other studies of the review. Other relevant differences in design or study population of the studies are mentioned in the discussion of the study results.

2.2.3 Analysis

To evaluate the effectiveness of the psychotherapy interventions three comparisons were made:

a) Psychotherapy versus care as usual by the GP or primary care physician (CAU)
b) Psychotherapy versus antidepressant drug treatment
c) Psychotherapy versus pill placebo.

Primary outcomes were mean end scores on continuous depression measures and remission percentages. To compare mean end scores of different depression measures, effect sizes (Cohen's d) were calculated by dividing the difference between the end scores of the intervention and control groups by the pooled standard deviation of the end scores. An effect size of less than 0.5 is considered to represent a small effect, an effect size of 0.5 – 0.8 represents a moderate effect and 0.8 or higher a strong effect of the intervention over the control condition (Cohen, 1988). A negative value of the effect size means that patients in the control condition improved more than those in the intervention group.

Effect sizes were calculated using Revman (version 4.1, The Cochrane Collaboration). Homogeneity of the different studies was explored by using the Cochran Q-test, a chi-square test (Cochran, 1954). If the p value of the Cochran Q-test was ≥ 0,1, studies were considered to be homogeneous, and a pooled effect size was calculated using a random-effects model (DerSimonian & Laird N, 1986).

2.3 Results

Eleven original studies were available for analysis. Two of them described the results of the same study at different time-points (Bedi et al., 2000; Chilvers et al., 2001). The relevant characteristics of the studies are summarised in Table 2.1.

Table 2.1. Main characteristics of the studies

Author	Number (n)	Intervention and control condition	Psycho-therapy sessions: number and duration	Inclusion criteria	Initial depres-sion severity: scale + mean score	Age (yrs.)	Follow -up
Barrett 2001	80 80 81	Paroxetine PST psychologist Placebo	6 3 ½ hours in total.	Dysthy-mia/ minor depression HRSD ≥10	HRSD 14.2 HSCLD 1.6	18-59	6 and 11 weeks
Bedi 2000 Chilvers 2001	51 52	Medication GP Counselling	6 Duration ?	Major depression according to RDC *	BDI 27	18-70	8 and 52 weeks
Friedli 1997	48 53	Counselling + CAU UC	6-12 50 minutes.	BDI≥14	BDI 24.3	≥ 18	3 and 9 months

Mynors-Wallis 1995	31 30 30	Amitriptyline PST psychiatrist or GP Placebo	6 3 ½ hours in total.	Major depression according to RDC * HRSD ≥13	HRSD 19 BDI 26	18-65	6 and 12 weeks
Mynors-Wallis 2000	36 39 41 35	Medication PST by GP PST by nurse Medication + PST by nurse	6 3 ½ hours in total.	Major depression according to RDC * HRSD ≥13	HRSD 19.8 BDI 30	18-65	6, 12, and 52 weeks
Schulberg 1996	91 93 92	Nortriptyline IPT psychiatrist or Psychologist CAU	20 45 minutes	Major de-pression HRSD≥ 13	HDRS 23	18-64	8 months
Scott 1992	31 30 30 30	Amitriptyline psychiatrist CBT psycholo-gist SW CAU	10 50 minutes	Depression according to DSM- IIIR	HRSD 18.7	18-64	4 and 16 weeks
Simpson 2000	92 89	Counselling + CAU CAU	6-12 1 hour	BDI ≥14 symptoms ≥ 6 months	BDI 21	18-70	6 and 12 months
Ward 2000	63 67 67	CBT psycholo-gist Counselling CAU	6-12 50 minutes.	BDI ≥14	BDI 26.5	> 18	4 and 12 months
Williams 2000	137 138 140	Paroxetine PST Placebo	6 3 ½ hours in total.	Dysthy-mia/ minor depression HRSD ≥10	HSCLD 1.4 HRSD 13.4	> 60	6 and 11 weeks

Note: CAU= Usual Care by the GP; PST = Problem Solving Therapy; CBT = Cognitive Behavioural Therapy; SW =Social Worker; * RDC=Research Diagnostic Criteria (Spitzer et al., 1978)

2.3.1 Characteristics of the selected studies

Interventions. Cognitive Behavioural Therapy (CBT, Beck, 1979), Interpersonal Psychotherapy (IPT, Klerman et al, 1984), and Problem Solving Therapy (Hawton & Kirk, 1989; Nezu & Nezu, 1989) are the psychotherapies that were used in the included studies. Additionally, the effectiveness of counselling was studied (Rowland et al., 2001). Counselling is not described in a manual and therefore more heterogeneous in its process. It is carried out by professionals with different therapeutic backgrounds. If available, the therapist's profession is presented in Table 2.1. In two studies (Friedli et al., 1997; Simpson et al., 2000) a small percentage (<30%) of the patients received a combination treatment of counselling and antidepressants. Despite this, we included these studies, because we did not want to further reduce the limited number of available studies.

Control conditions. The CAU as a control condition does not follow a protocol of course, and may therefore differ considerably between general practices. The drug and placebo treatments were carried out according to a protocol.

Inclusion criteria. In three studies, a score of 14 or more on the Beck Depression Inventory (BDI) was the inclusion criterion (Lasa et al., 2000). In the other studies, a cut-off score on a depression severity scale in combination with a diagnosis of depression were used as inclusion criteria.

Outcome measures. The outcome measures are presented in Table 2.1. They consist of self-report instruments (BDI; Hopkins Symptom Check List- Depression -20) and observer rating scales (Hamilton Rating Scale for Depression -17).

2.3.2 Methodological quality of the selected studies

Internal validity was assessed using the "Amsterdam-Maastricht-Consensuslijst". We found that one study had a very pragmatic design (Bedi, 2000) and therefore the internal validity may have been insufficient. In the other studies the internal validity was satisfactory. As there were hardly any differences in validity scores between these studies, we did not use these scores in the meta- analysis.

2.3.3 Psychotherapy compared with usual GP care (CAU)

The different outcome measures, remission percentages and standardised mean differences (SMDs), revelealed comparable results. We only present the results of the continuous outcome measures. Table 2.2 summarizes the mean end scores on the depression severity measures in the different studies. These end scores were used to calculate the SMD's. In Figure 2.1, the SMDs are presented. The pooled SMD is 0.31 (95% BI: 0.12 - 0.50), meaning that, overall, psychotherapy had slightly more effect than CAU. It is remarkable that Simpson (2000)

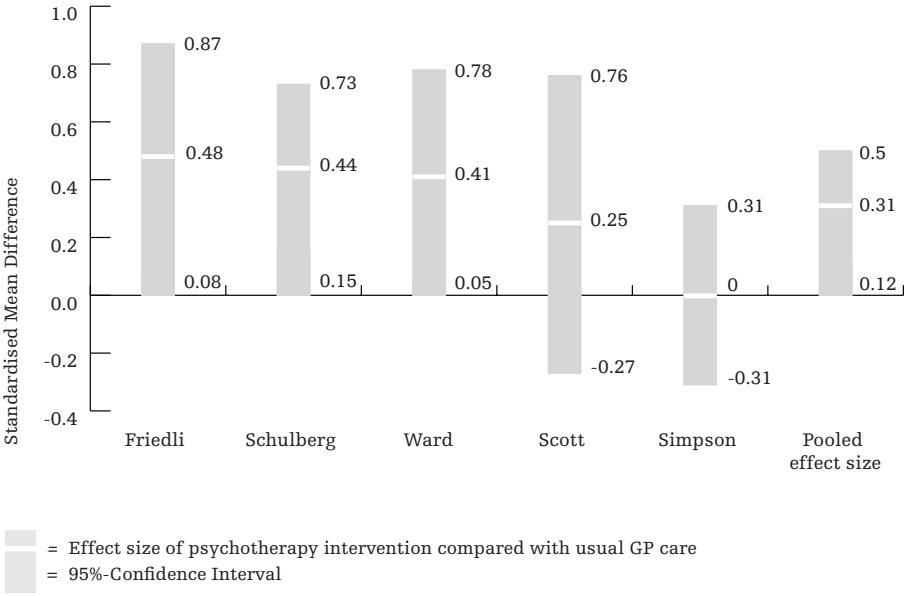
and Scott (1992) did not find a significant difference between psychotherapy and CAU. These studies are distinct from the others in that the mean baseline scores were relatively low (See Table 2.1). In the study of Simpson an additional inclusion criterion was that patients had to have depressive symptoms for more than six months. In some of the studies of this comparison a follow-up assessment was carried out at one year (Table 2.1). The effects of the intervention were smaller after one year.

Table 2.2. Psychotherapy compared with usual GP care

Study (Measure)	Psychotherapy		Usual GP care	
	n	Mean end score (SD)	n	Mean end score (SD)
Friedli (BDI)	48	13.50 (8.20)	53	18.00 (10.30)
Schulberg (HRSD)	93	9.30 (8.68)	92	13.10 (8.63)
Ward (BDI)	56	12.70 (9.50)	62	17.20 (11.90)
Scott (HRSD)	29	6.70 (6.10)	29	8.40 (7.50)
Simpson (BDI)	82	16.00 (9.30)	79	16.00 (8.10)

Note: SD= standard deviation

Figure 2.1. Psychotherapy compared with usual GP care.



2.3.4 Psychotherapy compared with antidepressant drug treatment by the GP. Seven studies were available for this comparison (Table 2.3). Figure 2.2 shows that on the continuous measures none of the studies demonstrated a significant difference between psychotherapy and medication. The pooled effect size was –0.08 (95% BI: -0.21 - 0.05). In the comparison using remission percentages as an outcome measure (not presented), it was found in one study that drug treatment was more effective than psychotherapy in patients with dysthymia, the difference in remission percentage was 23% (95% BI: 2-44%;Barrett et al., 2001). This finding was not replicated in a parallel study with the same design but focussing on elderly patients (Williams et al., 2000).

Table 2.3. Psychotherapy compared with antidepressant drug treatment

Study (Measure)	Psychotherapy		Antidepressants	
	n	Mean end score (SD)	n	Mean end score (SD)
Scott (HRSD)	29	6.70 (6.10)	26	8.00 (8.50)
Mynors-Wallis '95 (HRSD)	29	7.10 (6.70)	27	8.10 (7.10)
Bedi (BDI)	39	15.10 (9.69)	43	15.00 (9.67)
Schulberg (HRSD)	93	9.30 (8.68)	91	9.00 (9.54)
Barrett (HSCLD)	80	0.79 (0.80)	80	0.88 (0.72)
Williams (HSCLD)	138	0.52 (0.59)	137	0.61 (0.59)
Mynors-Wallis '00 (HRSD)	36	8.70 (8.52)	34	6.20 (7.35)

Figure 2.2. Psychotherapy compared with antidepressant drug treatment.

= Effect size of psychotherapy intervention compared with antidepressant drug treatment
= 95%-Confidence Interval

2.3.5 Psychotherapy compared with placebo medication.

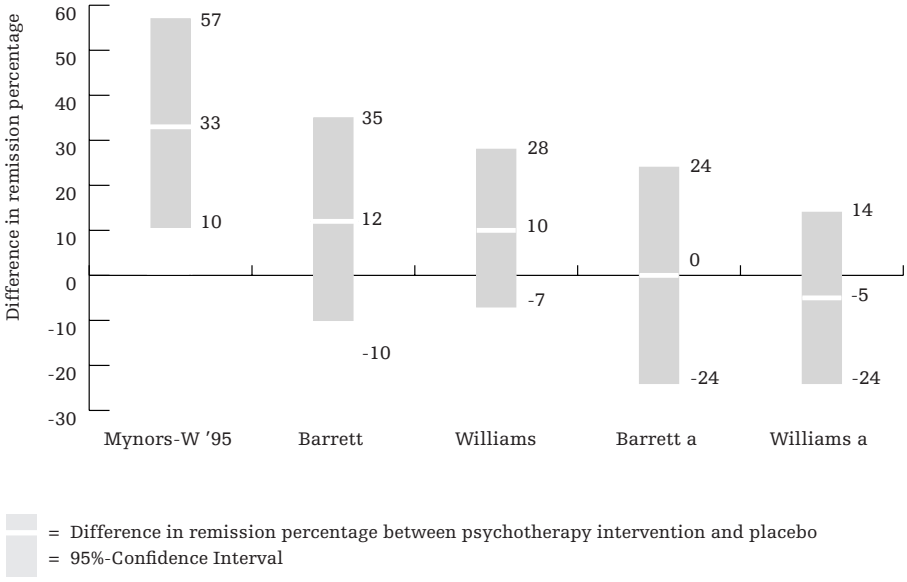
Because problem-solving treatment (PST) was developed for use in primary care, its efficacy first had to be demonstrated. Therefore, the design of the PST studies was less pragmatic than that of the other studies in this review. Placebo medication was used as the control condition. The three PST studies differed with regard to inclusion criteria: Mynors-Wallis (1995) focused on patients with major depression, Barrett (2001) and Williams (2000) on patients with minor depression and dysthymia. The study sample of Williams consists of elderly patients (>60 yrs.). We present the dichotomous outcome measures here, because Barrett and Williams made an interesting distinction between dysthymic disorder and minor depression regarding the remission percentages (Table 2.4). Figure 2.3 presents the differences in remission percentage. This difference is 33 % (95% BI: 10-57 %) in favour of the psychotherapy intervention in the study of Mynors-Wallis on adult patients with major depressive disorder. In patients with dysthymia and minor depression this difference was smaller and not significant. Pooling of the data is not useful because of the differences in patient populations.

Table 2.4. Psychotherapy compared with placebo

Study	Psychotherapy n remission / n total	Placebo n remission / n total
Barrett	21/37	16/36
Barrett a	19/29	21/32
Williams	32/63	25/62
Williams a	22/50	28/57
Mynors-W '95	18/30	8/30

Note:
Barrett and Williams: patients with dysthymia
Barrett a and Williams a: patients with minor depression

Figure 2.3. Psychotherapy (PST) versus placebo.



2.3.6 Conclusion

Psychotherapy for patients with major depressive disorder was slightly more effective than usual GP care. No significant differences in effectiveness were found between psychotherapy and antidepressant drug treatment by the GP (seven studies). In one study, drug treatment was more effective than psychotherapy in the treatment of dysthymia in adult patients. Problem solving treatment was significantly more effective than placebo medication in adult patients with major depressive disorder. PST was not effective in patients with dysthymia and minor depression. No studies were found that specifically studied the effectiveness of psychotherapy in elderly primary care patients with major depressive disorder.

2.4 Discussion

A limitation of this review is that only ten randomised controlled trials were available. These ten trials could not be used in all the three comparisons we wanted to make. In addition, the studies differed considerably for example regarding the inclusion criteria, the interventions and time of follow-up assess-

ments. Therefore, the results should be interpreted with some caution. However, despite these shortcomings and differences, the results were quite unambiguous.

We conclude that psychotherapy is a good alternative to antidepressants in general practice. Yet, there still remain many questions. For example, we do not know which of the treatment conditions works for whom, or whether there are differences in effectiveness between the psychotherapy interventions. The finding that PST was more effective for major depression than for dysthymia and minor depression is interesting and should be further studied, not only regarding PST but also in relation to the other psychotherapies. In a post-hoc analysis Friedli (1997) found a significant difference between counselling and CAU in patients with major depressive disorder (BDI≥14), but not in the whole study sample (inclusion criterion "emotional problems"). Elkin (1995) also found that there was a significant difference in efficacy of specific depression treatments (IPT, antidepressants) compared with placebo medication in the subgroup of patients with more severe depression (HRSD ≥20), while in the whole study sample, including patients with mild depression, this difference was not significant. Thus, future research should focus on the (differential) effect of baseline depression severity on treatment outcome. Schulberg (1998a) explored in a post-hoc analysis whether IPT was also as effective as medication in patients with more severe (non-psychotic) depression (HRSD ≥ 20). Indeed, he did not find a difference in effectiveness of these interventions in patients with more severe depression, although patients treated with IPT improved a few weeks later.

Another interesting question is what the optimal "dose" of psychotherapy sessions is. It is remarkable that PST, with a total intervention time of less than half that of IPT or CBT, was also effective for major depressive disorder. Furthermore, it was demonstrated that nurses or GPs could deliver this therapy. This raises the question of whether mental health workers, other than psychotherapists can be trained in IPT and CBT too.

What are the consequences of our findings for the treatment of depression in general practice? As the effectiveness of psychotherapy and antidepressant drug treatment does not seem to differ, patients can be offered the choice. However, antidepressant drug treatment can be given by the GP him/herself, which makes it more easily accessible than psychotherapy, and therefore preferable for many patients. The direct costs of psychotherapy are most probably higher than that of drug treatment by the GP, and it is not yet known whether this is compensated by, for example, a decrease in medical consumption. It should be noted that there are patients who prefer psychotherapy, who are explicitly not

motivated for drug treatment, who do not tolerate it, and who do not want to be referred for psychotherapy. Future study should explore whether it is feasible to introduce evidence-based psychotherapy in general practice for these patients.

CHAPTER 3

Cost-effectiveness of psychological treatments for depression in primary care

Bosmans JE, Van Schaik DJF, De Bruijne MC, Van Hout HPJ, Van Marwijk HWJ, Van Tulder MW, and Stalman WAB. (Submitted).

ABSTRACT

Objective To systematically review the cost-effectiveness of psychological treatments, psychotherapy and counselling, in adult primary care patients with depression.

Method A computer-assisted search of MEDLINE, EMBASE, CINAHL, PsycINFO, and the Cochrane Library was carried out. Two independent reviewers selected studies for the review, extracted data and assessed the methodological quality of the included studies.

Results In comparison with usual care, cognitive behavioural therapy was associated with insignificant differences in both costs and effects. Interpersonal therapy (IPT) was significantly more effective and expensive than usual care. It remains uncertain whether couple therapy and IPT are cost-effective in comparison with antidepressant therapy. There was no evidence for the cost-effectiveness of counselling in comparison with usual care or antidepressant treatment.

Conclusions Based on this review, no firm conclusions can be drawn on the cost-effectiveness of psychotherapy and counselling in primary care. Given the large economic impact of depression, there is a need for well designed and well powered economic evaluations of those psychological treatments that have proved to be most effective.

3.1 Introduction

Depression is an important health problem. The 6-month prevalence of major depression was 6.9% in a pan-European community survey (Lepine et al., 1997). Because depression is associated with increased work absenteeism (Broadhead et al., 1990) and increased health care costs (Manning & Wells, 1992; Simon et al., 1995), the societal costs of depression are high. Most patients with depression are treated in primary care (Lepine et al., 1997). There are two main treatment options: antidepressant drug treatment and psychological treatment. Antidepressants are effective in treating depression in primary care (Simon, 2002). However, antidepressants may have intolerable side effects. Moreover, a substantial group of patients is reluctant to use antidepressants and prefers psychological treatments (van Schaik et al., 2004).

The objective of this study was to systematically review the literature on the cost-effectiveness of psychotherapy and counselling in comparison with usual care by primary care physicians or with antidepressant drug treatment in depressed primary care patients.

3.2 Method

3.2.1 Search strategy

A computer-assisted search of MEDLINE (up to June 2004), EMBASE (up to June 2004), CINAHL (up to 21st May 2004), PsycINFO (up to 26th April 2004) and the Cochrane Library including the NHS Economic Evaluation Database (Issue 2, 2004) was carried out. Search terms and keywords used were "depression", "depressive disorder", "Economics", "Economics, Hospital", "Economics, Medical", "Economics, Nursing", "Costs and Cost Analysis", "Value of Life", "economic*", "cost", "costs", "expenditure*", "Primary Health Care", "family practice", "Physicians, Family", "primary AND care", "general pract*", "family pract*", "family physician*" and "general physician*". The full search strategy was developed with the help of an experienced librarian and is available on request. Additionally, references given in relevant identified publications and reviews were screened.

3.2.2 Study selection

Two reviewers (JB and AS) independently selected studies to be included in the systematic review by screening titles and abstracts of all publications downloaded from the electronic databases. Economic evaluations were included in the review if (a) the subjects of study were depressed adults who were considered to be eligible for depression treatment with exclusion of patients with

dysthymic or bipolar disorders, (b) the study contained a full economic evaluation (i.e. both costs and effects were presented), (c) the setting of the study was primary care, (d) the intervention tested in the study was aimed at the acute treatment of depressive symptoms, and (e) at least one of the treatment arms consisted of psychotherapy or counselling. Disagreements between reviewers about the eligibility of a study were resolved by consensus. A copy of the full article was retrieved for all eligible studies and for all studies in which there was any doubt about their eligibility. The final decision on the inclusion of a study was based on the full article.

3.2.3 Methodological quality assessment

The methodological quality of the economic evaluations was assessed independently by two reviewers (JB and AS/HH/HM) using a recently developed checklist (Evers et al., 2005). All items were scored as positive (+) or negative (-). Two reviewers (JB and AS/HH/HM) independently extracted data using a standardised form. Data were extracted on the study design, setting, study population, interventions, clinical outcomes, costs and cost-effectiveness. Again, disagreements were solved by consensus.

After exploring the cost and cost-effectiveness data it became clear that there were many differences between the included studies. Included cost categories varied widely and most studies did not present resource use separately from costs. Also, many different outcome measures were used. Therefore, it was not possible to pool the results in one meta-analysis. Rather than performing many small meta-analyses with few studies, we chose to undertake a narrative synthesis while focusing on the methodological quality of the studies.

3.3 Results

3.3.1 Literature search and study selection

The abstracts of 1580 potentially relevant articles identified by the search were screened, and the full publications of 28 articles were retrieved for further examination. Of these, 20 articles were excluded for the following reasons: subjects included in the study were not primarily depressed patients (Richards et al., 2003; Robson et al., 1984; Mynors-Wallis et al., 1997), the intervention tested in the study was a so called collaborative care model (Jarjoura et al., 2004; Katon et al., 2002; Liu et al., 2003; Pyne et al., 2003a; Pyne et al., 2003b; Schoenbaum et al., 2001; Simon et al., 2000; Simon et al., 2001a; Simon et al., 2001b; von Korff et al., 1998), cost and effect data were not reported (Finley et al., 2003), intervention tested in the study was not primarily aimed at the acute

treatment of depressive symptoms (Simon et al., 2002b; Sturm & Wells, 1995), the study did not present original data (Chisholm et al., 2004), and the study was an observational study (Katzelnick et al., 1997; Chisholm et al., 2003; Simon et al., 2002a). Six original studies (reported in eight articles) were available for analysis (Bower et al., 2000; King et al., 2000; Lave et al., 1998; Leff et al., 2000; Miller et al., 2003; Scott & Freeman, 1992; Simpson et al., 2000 and 2003). No other studies were identified through reference checking.

3.3.2. Study characteristics

Data on sample size, age, baseline depression score, and type of intervention are listed in Table 3.1. Five studies were conducted in the United Kingdom (Bower et al., 2000; Scott & Freeman, 1992; Leff et al., 2000; Miller et al., 2003; Simpson et al., 2003) and one was conducted in the United States of America (Lave et al., 1998). Follow up assessments ranged from 16 weeks to 24 months. The IPT and couple therapy "dose" (12-20 sessions) was relatively high compared with 5-12 sessions of counselling or Cognitive Behavioural Therapy (CBT) in the other studies. Finally, studies differed in the sources they used to collect resource use data.

3.3.3. Methodological quality of economic evaluations

The methodological quality assessment of the economic evaluations is presented in Table 3.2. All studies scored positively on at least 13 of the 19 methodological criteria, which can be considered to be a remarkably good score. The majority of the included studies gave a clear description of the study population and the competing alternatives, measured and valued costs and outcomes appropriately, and reported conclusions that followed from the reported data. In the following section, the most important aspects regarding the methodology of the included studies will be discussed in more detail.

Perspective. Economic evaluations can be performed from different perspectives. The perspective determines which cost categories have to be taken into account. The societal perspective, the broadest perspective, is usually recommended by health economists (Drummond & Jefferson, 1996), and indicates that all relevant outcomes and costs, regardless of who pays, are taken into account (Drummond et al., 2005). Sometimes a narrower perspective can be chosen, such as the perspective of insurance companies, health care providers or patients. One study used a societal perspective (Bower et al., 2000). One study that did not claim to have used a societal perspective, measured lost productivity costs,

Table 3.1. Main characteristics of economic evaluations of psychotherapy or counselling in depression in primary care.

Study	Clinical study	Interventions (N)	Mean (SD) baseline depression score	Mean (SD) age	Cost categories	Cost valuation
Scott 1992		CBT (30) Co (30) AD (31) UC (30)	HDRS CBT 18.3 (5.4) Co 15.7 (5.7) AD 18.2 (6.6) UC 19.7 (5.4)	CBT 28.8 (8.1) Co 36.2 (14.2) AD 30.6 (10.8) UC 31.6 (10.7)	Intervention costs.	Cost prices, charges/tariffs.
Lave 1998	Schulberg 1996	IPT (n=93) AD (n=91) UC (n=92)	BDI IPT 25.0 (9.4) AD 25.5 (11.4) UC 27.3 (9.7) HDRS IPT 22.3 (4.6) AD 23.7 (5.3) UC 23.4 (5.3)	IPT 37.1 (11.4) AD 38.6 (11.6) UC 38.6 (12.4)	Intervention + other health care costs, patient time and transportation costs.	Charges/tariffs. Human capital approach.
Bower 2000 King 2000	Ward 2000	CBT (63) Co (67) UC (67)	BDI CBT 25.4 (8.6) Co 26.5 (8.9) UC 27.6 (8.4)	CBT 36 (12.6) Co 39 (11.6) UC 37 (12.3)	Intervention + other health care costs, child care and travel costs, indirect costs.	Cost prices, charges/tariffs. Human capital approach.

Leff 2000		CT (n=40) AD (n=37)	BDI CT 25.4 (7.4) AD 28.1 (6.0) HDRS CT 18.1 (3.4) AD 18.7 (3.9)	CT 39.7 (12.5) AD 38.6 (9.2)	Intervention + other health care costs.	Cost prices.
Miller 2003	Chilvers 2001	Co (n=52) AD (n=51)	BDI Co 27.1 (8.0) AD 27.0 (8.0)	Co 37.3 (11.2) AD 38.4 (11.8)	Intervention + other health care costs.	Cost prices, charges/tariffs.
Simpson 2003, 2000		Co (n=73) UC (n=72)	BDI Co 22.0 (6.1) UC 19.7 (5.6)	Co 42 UC 44	Intervention + other health care costs.	Cost prices.

Note: UC = general practitioner usual care; CBT = cognitive behavioural therapy; Co = Counselling; AD = antidepressant drugs; IPT = interpersonal psychotherapy; CT = couple therapy; BDI = Beck Depression Inventory; HDRS = Hamilton Depression Rating Scale;

Table 3.2. Methodological quality assessment of economic evaluations.

		Scott	Lave	Bower	Leff	Miller	Simpson
1.	Is the study population clearly described?	+	+	-	+	+	+
2.	Are competing alternatives clearly described?	+	+	+	+	+	+
3.	Is a well-defined research question posed in answerable form?	+	+	+	+	+	+
4.	Is the economic study design appropriate to the stated objective?	+	+	+	+	+	+
5.	Is the chosen time period appropriate in order to include relevant costs and consequences?	-	+	+	+	+	+
6.	Is the actual perspective chosen appropriate?	-	-	+	-	-	+
7.	Are all important and relevant costs for each alternative identified?	-	-	+	-	-	+
8.	Are all costs measured appropriately in physical units?	+	+	+	+	+	+
9.	Are costs valued appropriately?	+	+	+	+	+	+
10.	Are all important and relevant outcomes for each alternative identified?	+	+	+	+	+	+
11.	Are all outcomes measured appropriately?	+	+	+	+	+	+
12.	Are outcomes valued appropriately?	+	+	+	+	+	+
13.	Is an incremental analysis of costs and outcomes of alternatives performed?	-	+	-	-	+	-
14.	Are all future costs and outcomes discounted appropriately?	+	+	+	-	+	+
15.	Are all important variables, whose values are uncertain, appropriately subjected to sensitivity analysis?	-	-	+	-	-	-
16.	Do the conclusions follow from the data reported?	+	+	+	+	+	+
17.	Does the study discuss the generalisability of the results to other settings and patient/client groups?	+	+	-	+	-	+
18.	Does the article indicate that there is no potential conflict of interest of study researcher(s) and funder(s)?	+	+	+	+	+	+
19.	Are ethical and distributional issues discussed appropriately?	-	-	-	-	-	-
Total		13	15	15	13	14	16

Note: Each item scored as positive (+) or negative (-).

but excluded them from the analysis because there were no between-group differences at any of the time points (Simpson et al., 2003).

Costs. Cost categories that are usually distinguished in economic evaluations are direct health care costs (for example primary care and medication costs), direct non-health care costs (for example patient time and transportation costs), and indirect costs (for example productivity costs due to work absenteeism). As stated earlier, the cost categories included in the studies of this review varied considerably. Also, few studies gave a clear description of included cost categories (Table 3.1). Different sources were used to collect resource use data: administrative databases (Lave et al., 1998), medical records (Bower et al., 2000; Scott & Freeman, 1992; Miller et al., 2003; Simpson et al., 2003), trial records (Lave et al., 1998), patient interviews (Bower et al., 2000; Scott & Freeman, 1992), and self-report questionnaires (Lave et al., 1998; Leff et al., 2000; Simpson et al., 2003).

Outcomes. All studies included some measure of depression severity, including the Beck Depression Inventory (BDI), and the Hamilton Depression Rating Scale (HDRS) (Table 3.3). One study calculated Depression Free Days (DFDs) and Quality Adjusted Life-Years (QALYs) (Lave et al., 1998). To calculate DFDs, each day in an interval between 2 assessments is assigned a value between 1 ("depression free") and 0 ("fully symptomatic") based on cut-off values on a clinical depression scale using a linear interpolation of clinical ratings at the beginning and end of the interval. The obtained DFDs were transformed into quality-adjusted life years by weighting them using utilities assigned to depression from literature (Lave et al., 1998).

Table 3.3 Outcomes of economic evaluations of psychotherapy or counselling in depression in primary care.

Study	Costs	Effects	Cost effective-ness
Scott 1992	Therapist's time costs (£)** AD 113 (70)† CBT 115 (62) Co121 (40) UC 26 (32)‡ † including cost of amitriptyline mean cost was £120 ‡ including drug costs mean cost was £34. including costs of other NHS staff and resources mean cost was £55	HDRS* CBT vs UC –1.7 (-5.3; 1.9) Co vs UC –3.5 (-7.0; 0.0) AD vs UC –0.4 (-4.8; 3.9) Recovery rate CBT vs UC -0.07, p=NS Co vs UC 0.24, p=0.05 AD vs UC 0.10, p=NS UC 0.48	NA
Lave 1998	Direct costs (US $)** IPT 1398.57 (840.94) AD 1291.41 (842.80) UC 553.20 (490.48) F=35.32, p<0.001) Indirect costs (US $)** IPT 366.25 (242.63) AD 214.74 (145.95) UC 122.48 (108.17) F=45.58, p<0.001 Total costs (US $)** IPT 1764.83 (1068.13) AD 1506.16 (974.79) UC 675.67 (575.29) F=36.97, p<0.001	Mean DFD's based on BDI IPT 187, AD 220, UC 148, F=8.96, p=0.01 Mean DFD's based on HDRS IPT 234, AD 243, UC 185, F=10.11, p<0.01	Cost per DFD based on HDRS AD vs UC 14.79, p<0.01 IPT vs UC 29.36, p=0.04 Cost per DFD based on BDI AD vs UC 11.44, p<0.01 IPT vs UC 32.44 p=0.70
Bower 2000	Direct costs (£)* UC vs CBT 24.0 (-201.3; 249.3) UC vs Co –28.5 (-268.4; 211.3) Indirect costs (£)* UC vs CBT 133.1 (-424.0; 690.2) UC vs Co -152.5 (-864.7; 559.6) Total costs (£)* UC vs CBT 157 (-458.0; 772.2) UC vs Co –181.1 (-951.9; 589.7)	BDI** CBT 9.3 (8.8) Co 11.1 (9.3) UC 10.2 (8.5) F=1.41; df=2, 191; p=0.25 EuroQol NS	NA

Leff 2000	Direct costs (£ per month) during treatment period* CT vs AD 5 (-76; 71) Direct costs (£ per month) during follow-up period* CT vs AD -24 (-83; 25)	BDI* CT vs AD 6.4 (1.62; 11.54) HDRS* CT vs AD NS	NA
Miller 2003	All depression-related health services costs (£)*** Co 301.63 (225.91; 377.35) AD 343.64 (219.45; 467.82) p=0.56	Global outcome using the RDC, BDI and GP notes Good or moderate Co 29/52, AD 33/51, p=0.85 Good Co 13/52, AD 21/51, p=0.20	Cost-effectiveness acceptability curve AD vs Co R_c=0 $p_{cost\text{-}effective}$=0.45
Simpson 2003	Direct costs (£)* Co vs UC -28 (-597; 588)	BDI** Co 15.3 (10.3) UC 15.0 (8.1) F=0.35, p=NS Number of cases (BDI ≥ 14 (%) Co 29/60 (48) UC 35/55 (64) OR=0.36 (0.15; 0.85)	NA

Note: UC = primary care physician usual care; CBT = cognitive behavioural therapy; Co = counselling; AD = antidepressant treatment; IPT = interpersonal psychotherapy; CT = couple therapy; BDI = Beck Depression Inventory; HDRS = Hamilton Depression Rating Scale; QALYs = Quality Adjusted Life-Years; NS = not significant; NA = Not Applicable

* Mean (95% CI) difference

** Mean (SD)

*** Mean (95% CI)

Incremental costs and cost-effectiveness analysis. In a full economic evaluation costs and effects of two or more interventions are compared. The first step is to analyse costs and effects separately. Costs typically have a heavily skewed distribution, which is usually due to a few patients who incur high costs. Nevertheless, the arithmetic mean is the most informative measure for policy makers, because the estimated mean costs can be easily converted into the required information on the total costs needed to treat all patients. T-tests and other parametric methods are only appropriate to compare mean costs, if the costs are reasonably

normally distributed. Parametric analysis of log-transformed costs, leads to a comparison of geometric means instead of arithmetic means. Non-parametric methods are not appropriate to compare costs, because those methods provide no statistical test of the mean costs, but of the cost distributions. Therefore, nowadays the preferred method to analyse cost data is bootstrapping. With bootstrapping statistical analysis is based on repeated sampling with replacement from the observed data. Subsequently, 95% confidence intervals around the observed mean difference in total costs between the compared treatment groups are calculated based on the distribution of the resamples (Barber &Thompson, 2000; Thompson & Barber, 2000). Before the widespread use of bootstrapping, it was standard practice to use parametric tests of log-transformed costs or to use non-parametric tests. Of the included studies, four studies used bootstrapping to analyse differences in mean costs between the treatment groups (Bower et al., 2000; Leff et al., 2000; Miller et al., 2003; Simpson et al., 2003). The two other included studies used analysis of variance to compare costs between the groups (Scott & Freeman, 1992; Lave et al., 1998).

The second step in a full economic evaluation is to directly evaluate costs and effects in an incremental cost-effectiveness ratio (ICER). The ICER is calculated by dividing the difference in mean total costs between the treatment groups by the difference in mean effects. In a cost-effectiveness analysis the effects are expressed in any clinical outcome measure such as the BDI or recovery rate. In a cost-utility analysis the effects are expressed in QALYs. Bootstrapping can be used to calculate 95% confidence intervals around the ICERs. However, the interpretation of the confidence interval around an ICER is ambiguous. Nowadays, bootstrap estimates are preferred for calculating cost-effectiveness planes and acceptability curves, which are more useful in the interpretation of the uncertainty around an ICER. Cost-effectiveness planes give an indication of the variation in the ICER (Black, 1990) and acceptability curves show the probability that a treatment is cost effective at a specific ceiling ratio (Van Hout et al., 1994).

Although all included studies were considered a cost-effectiveness analysis or a cost-utility analysis (Lave et al., 1998), four studies did not perform an incremental cost-effectiveness analysis (Bower et al., 2000; Scott & Freeman, 1992; Leff et al., 2000; Simpson et al., 2003). One study presented a point estimate of the ICER and an accompanying significance test for the ICER based on bootstrapping (Lave et al., 1998). A cost-effectiveness plane and a cost-effectiveness acceptability curve using bootstrap estimates were presented by one other study (Miller et al., 2003).

Sensitivity analysis. In a sensitivity analysis the robustness of the results is assessed by varying the values of the key parameters in the study. Since there is much uncertainty associated with cost measurement and valuation, sensitivity analysis is particularly important in economic evaluations. Two studies included a sensitivity analysis (Bower et al., 2000; Miller et al., 2003) of which one was considered appropriate (Bower et al., 2000) and the other one was considered incomplete by the authors (Miller et al., 2003).

3.3.4. Cost-effectiveness

Psychotherapy in comparison with usual care. CBT was compared with usual care (UC) in two studies (Scott & Freeman, 1992; Bower et al., 2000). In an early cost-effectiveness study, Scott and Freeman found remarkable improvement in both the CBT and UC group, but no significant differences in HDRS scores at 16 weeks between CBT and UC. Only intervention costs were included in this study, which made it impossible to investigate a possible cost-offset effect in other health care costs, and cost differences were not statistically tested. The intervention costs in the CBT group were approximately 4.5 times higher than in the UC group. No incremental cost-effectiveness analysis was performed. In the well-designed study by Bower et al. CBT was more effective than UC in the short-term (4 months). However, there were no significant differences in effects at 12 months, and no significant differences in direct, indirect or total societal costs were found. No incremental cost-effectiveness analysis was performed in this study.

Lave et al. (1998) compared IPT with UC. Patients in the IPT group experienced significantly more DFDs than patients in the UC group. Direct and total costs were significantly higher in the IPT group, which could be attributed to the IPT costs. The extra cost per DFD gained in the IPT group in comparison with the UC group was $29.36.

Psychotherapy in comparison with antidepressant drug treatment. Couple therapy (CT) was compared with antidepressant treatment (AD) by Leff et al.(2000). They found that CT had significantly greater effects on the BDI than AD, but not on the HDRS. The costs per month did not differ significantly between the two treatment groups. An incremental cost-effectiveness analysis was not performed. However, it should be noted that more than half of the patients in the AD group did not receive antidepressants as allocated.

In the study by Lave et al. (1998), patients in the AD group experienced somewhat more DFDs than patients in the IPT group. The direct and total costs in the IPT group were higher than in the AD group. However, these differences were not statistically significant.

Counselling in comparison with usual care. Counselling was compared with usual care in three studies. In the study by Scott & Freeman (1992) a borderline statistical difference in clinical effects in favour of the counselling group was found. Only intervention costs were included in this study and incremental costs and cost-effectiveness analyses were not performed. Bower et al. (2000) found no significant differences in effects and costs in their study. No incremental cost-effectiveness analysis was performed. In the most recent study by Simpson et al. (2003) no significant difference in depression severity between the treatment groups was found at the end of the follow-up. However, they found a significant difference in the number of depression cases in favour of the counselling group at the end of the follow-up period. Primary care costs were increased in the short term, which was linked to the use of counselling services. There were no significant differences in costs at 12 months. An incremental cost-effectiveness analysis was not performed.

Counselling in comparison with antidepressant drug treatment. Miller et al. (2003) compared counselling with antidepressant treatment. They found no significant differences in effects and costs. Cost-effectiveness planes and acceptability curves indicated that there was no significant difference in cost-effectiveness between the two treatment groups.

3.4 Discussion

This article systematically reviewed economic evaluations of psychological treatments in depressed primary care patients. Six studies were included in the review that all scored at least 13 out of 19 in the methodological assessment of the studies. Based on this review, no firm conclusions on the cost-effectiveness of CBT in comparison with usual care can be drawn. IPT was significantly more effective than usual care, but was associated with significantly higher costs. In this case it is up to decision makers in the health care sector whether the additional costs associated with the additional benefits are worth it. IPT was also compared with antidepressant treatment; in this comparison there were no significant differences in costs and effects. The last form of psychotherapy that was evaluated in the studies included in this review, was couple therapy, for which it remains uncertain whether it is cost-effective in comparison with antidepressant treatment. The evidence for the cost-effectiveness of counselling in comparison with usual care is limited.

Most studies had methodological shortcomings, of which the most important are mentioned below. These shortcomings are partly caused by the introduction of new methods in the field of health technology assessment after

publication of some of the included studies. Only two studies were performed from a societal perspective and included lost productivity costs. The other four studies did not include lost productivity costs. Given the high costs of productivity losses associated with depression, this is a limitation of these studies.

Although all studies employed an appropriate design and could be considered a cost-effectiveness or cost-utility study, four studies did not present an incremental cost-effectiveness analysis. One could argue that non-significant effects justify the omission of an incremental cost-effectiveness analysis in an economic evaluation, resulting in a cost minimisation analysis. However, since 'absence of evidence is not evidence of absence', Briggs & O'Brien (2001) argue that a cost minimisation analysis is only appropriate when a study has been specifically designed to show the equivalence of treatments. In all other cases, the focus should be on estimation of cost-effectiveness, for example by presenting the results in a cost-effectiveness plane.

An important problem in economic evaluations is the power. Because costs typically have a heavily skewed distribution, large sample sizes are needed to detect differences in costs (Briggs, 2000). Most studies recognised this problem with the power and made a remark on it. Bower et al. (2000) pooled individual patient data to overcome sample size limitations in economic analyses. They showed that the included studies may have been underpowered to detect differences in costs between the treatment groups and that this problem can be overcome by a meta-analysis.

There are several possible ways to improve the cost-effectiveness of psychotherapy in primary care. One is to provide psychotherapy as part of a collaborative care model as was done in two studies by Von Korff et al. (1998) and Schoenbaum et al. (2001). In these studies, substantial clinical effects were found. Thus, the cost-effectiveness of depression treatment on the whole may be improved by incorporating psychotherapy into enhanced care models, tailored to the needs of individual patients. Also, the cost-effectiveness of psychological treatments may be improved when treatment is given by trained nurses instead of by psychotherapists, as has been demonstrated for problem-solving therapy by Mynors-Wallis et al.(1997).

In conclusion, as psychotherapy is a good alternative to antidepressant drug treatment for patients who do not benefit (enough) from antidepressant drug treatment or who are reluctant to use these medicines, and because depression has a large economic impact, there is a need for better designed, and better conducted economic evaluations of psychological treatments for depression in primary care. Since psychotherapy seems to have more substantial clini-

cal effects than counselling, the emphasis should be on economic evaluations of those forms of psychotherapy that have proved to be effective. In addition, research is needed to identify ways to improve the cost-effectiveness of psychological treatments in primary care.

CHAPTER 4

Patients' preferences in the treatment of depressive disorder in primary care.

Van Schaik DJF, Klijn AFJ, Van Hout HPJ, Van Marwijk HWJ, Beekman ATF, De Haan M, and Van Dyck R. (2004). General Hospital Psychiatry, 26(3): 184-189.

Abstract

Background Patients' preferences in the treatment of depression are important in clinical practice and in research. Antidepressant medication is often prescribed, but adherence is low. This may be caused by patients preferring psychotherapy, which is often not available in primary care. In randomised clinical trials, patients' preferences may affect the external validity.

Aim To study patients' preferences regarding psychotherapy and antidepressant medication and the impact of these preferences on treatment outcome.

Method A systematic review of the literature was performed.

Results The majority of patients preferred psychotherapy in all available studies. Antidepressants were often regarded as addictive and psychotherapy was assumed to solve the cause of depression. Discussing and supporting preferences as part of a quality improvement programme of depression care, resulted in more patients receiving the treatment that was most suitable to them. In two patient preference trials preferences did not influence treatment outcome.

Conclusion A substantial percentage of well-informed patients prefer psychotherapy. Patients with strong preferences, mostly for psychotherapy, are likely not to enter antidepressant treatment or randomised clinical trials if their preferences are not supported.

4.1. Introduction

In recent years patients' treatment preferences and their impact on depression care have received growing interest, not only because "patient-centered" medicine has influenced health care in general (Laine & Davidoff, 1996) but also because it is thought that taking account of patients' preferences may improve compliance (Dwight-Johnson et al., 2000). From a research perspective, it has been argued that patients' treatment preferences influence patient selection, treatment compliance and attrition in randomised clinical trials. Therefore, the external validity of clinical trials is affected by these preferences and alternative study designs have been used that incorporated patients' preferences into the study design (Ten Have et al., 2003).

Antidepressant medication and short-term psychotherapies, such as Interpersonal Psychotherapy (IPT), Cognitive Behavioural Therapy (CBT) and Problem Solving Therapy (PST) are equally effective. In addition, counselling is often provided. However, counselling is not a manual based psychotherapy and therefore heterogeneous in its process. Its effectiveness has not been sufficiently demonstrated (Schulberg et al., 2002).

Patients with major depressive disorder in primary care are generally offered treatment with antidepressant medication, because psychotherapy is mostly not available. Prescribing medication fits more easily into the routine practice of the physician. It has been found that general practitioners prescribed antidepressant medication during the first visit in which depression was diagnosed in 73 % of cases (Van Marwijk et al., 2001). Yet, in another study it was observed that 50% of patients ceased taking the antidepressants within six weeks (Lawrenson et al., 2000). Although several factors contribute to compliance problems, divergent views between patient and physician with regard to type of treatment may be a crucial component. The beliefs held by the general public about mental disorders differ substantially from those of health practitioners (Jorm et al., 1997), and patients often prefer psychotherapy to antidepressants(Dwight-Johnson et al., 2000; Simpson et al., 2000). Patient choice and autonomy should be valued, but more knowledge about patients' preferences and their influence on the treatment process is necessary to learn to what extent the preferences should be supported by changes in the organisation of primary care practice.

As patients' preferences are affected by attitudes and beliefs of the general public, it is not only findings from surveys carried out in depressed primary care populations that are of interest but also surveys conducted in non-depressed populations. Furthermore, findings from clinical trials in which atten-

tion has been paid to patients' preferences are relevant to understand more about preferences and their influence on treatment outcome.
The research questions of this review are:

1. Which treatment do people with and without depression prefer for depressive disorder in primary care?
2. What are the underlying assumptions and associated factors of patients' preferences?
3. Do patients' preferences affect treatment compliance and outcome in clinical trials?

4.2. Method

4.2.1 Identification of relevant publications

Two systematic searches of Medline, PsychInfo and the Cochrane Library were performed separately for depressed primary care populations and for primarily non-depressed general populations over the period 1990 - January 2003. To retrieve studies in depressed primary care populations we used the following medical subject headings and key words: depressive disorder/therapy, depression/therapy, depression, psychotherapy, counselling, antidepressants, patient satisfaction, preference, family practice, general practice, and primary care.
To find surveys carried out in the general population we used the subsequent headings and keywords: depressive disorder/therapy, depression/therapy, public attitude, belief, general public, and lay public. All studies that presented data about attitudes or preferences towards psychotherapy and antidepressant medication were included. References from relevant articles were explored.

4.2.2. Data extraction and analysis

From all surveys, percentages of respondents with a positive attitude towards psychotherapy and antidepressants were extracted. Differences between these percentages were calculated. In addition, arguments underlying these preferences and factors associated with them were summarized. Data about the influence of depressed patients' preferences on entry into treatment, compliance, treatment outcome and satisfaction were summarized.

4.3. Results

4.3.1 Preferences among depressed primary care patients and among non-depressed primary care or general populations

Nine articles, concerning six studies, were identified as presenting preference data of depressed primary care patients (Bedi et al., 2000; Chilvers et al., 2001;

Table 4.1. Treatment preferences of depressed primary care patients.

Author	Country	Age	Study design	Number of participants	% Preferring PT or C	% Preferring AD	Difference in %
Bedi 2000 Chilvers 2001	UK	18-70	Partially randomised Preference trial	220	64 C	36	28
Cooper-Patrick, 1997	USA	>18	Focus group	16	Not presented	Not presented	Not applicable
Dwight-Johnson 2000 and 2001	USA	18-90	Survey among depressed primary care patients	1187	55 C	27	28
King 2000 Ward 2000	UK	≥ 18	Controlled trial with randomised and patient preference allocation arms	457	43 C 26 PT	20	23 6
Simpson 2000	UK	18-70	Randomised controlled trial	180	66 C	28	38
Unützer 2002	USA	≥ 60	Randomised controlled trial	1801	51 PT	38	13

Note: PT= psychotherapy; C=counselling; AD=antidepressants

Cooper-Patrick et al., 1997; Dwight-Johnson et al., 2000; Dwight-Johnson et al., 2001; King et al., 2000; Simpson et al., 2000; Unützer et al., 2002; Ward et al., 2000). Relevant characteristics of the studies are presented in Table 4.1. Articles presenting data of the same studies are presented in one row. From Table 4.1 it can be seen that in studies comparing counselling with antidepressants 23% - 38% more patients preferred counselling. In the two studies comparing psychotherapy with antidepressants the differences were 6% and 13 % favouring psychotherapy. In the study of King et al. (2000) both counselling and psychotherapy were rated; it turned out that counselling was preferred more often. One study only presented qualitative data (Cooper-Patrick et al., 1997).

We selected nine articles, about seven studies, presenting percentages of positive attitudes towards antidepressant medication and psychotherapy or counselling in general (nondepressed) populations (Althaus et al., 2002; Angermeyer & Matschinger, 1999; Angermeyer et al., 1993, 1996; Benkert et al., 1997; Jorm et al., 1997; Lauber, et al., 2001; McKeon et al., 1991; Paykel et al., 1998). Three additional surveys were included that had been carried out in primarily nondepressed primary care populations (Brody et al., 1997; Churchill et al., 2000; Zeitlin et al., 1997). Table 4.2 shows the relevant characteristics of the selected surveys. Articles presenting data of the same studies are presented in one row. Paykel et al. (1998) reported the results of three surveys of public attitudes at the start, during and at the end of the Defeat Depression Campaign in Great Britain. We present the results of the last survey.

Table 4.2 indicates that in all studies respondents had a more positive attitude towards psychotherapy or counselling than towards medication. 5% to 66% more respondents preferred psychotherapy or counselling compared with antidepressant medication.

Table 4.2 Treatment preferences in nondepressed populations

Author	Number of Participants	Survey population	Country	Age	% Positive about PT or C	% Positive about AD	Difference in %
Althaus 2002	1426	GP	Germany	18-99	77 PT	32	45
Angermeyer 1993,1996, 1999	843	GP	Germany	≥ 18	44 PT	17	27
Benkert 1997	1088	GP	Germany	≥ 16	64 PT	26	38
Brody 1997	130	PCP	USA	15-75	62 C	23	39
Churchill 2000	895	PCP	UK	≥ 18	51 C	15	36
Jorm 1997	1010	GP	Australia	18-74	34 PT	29	5
Lauber 2001	873	GP	Switzerland	16-76	36 PT	25	11
McKeon 1991	1403	GP	Ireland	≥ 16	32 C	23	9
Paykel 1999	1946	GP	UK	≥ 15	90 C	24	66
Zeitlin 1997	180	PCP	UK	18-86	98 C	35	63

Note: GP= general population; PCP= primary care population PT= psychotherapy; C=counselling; AD=antidepressants

4.3.2 Underlying assumptions and associated factors

It has been found that the most important argument against psychotropic drugs, mentioned by 33-80% of the respondents, was the risk of undesirable side effects and addiction (Althaus et al., 2002; Angermeyer & Matschinger, 1996; Churchill et al., 2000; Cooper-Patrick et al., 1997; Paykel et al., 1998). At the end of the Defeat Depression Campaign 60% still believed antidepressants to be addictive. This proportion had fallen by only 4% over the period of the campaign (Paykel et al., 1998). Benkert et al. (1997) compared the attitudes towards psychotropic drugs with attitudes towards drugs for "physical" diseases such as cardiac drugs. It seemed clear that psychotropic drugs were believed to cause signifi-

cantly more side effects and to provoke more fear of losing control. A positive argument mentioned in the study of Angermeyer & Matschinger (1996) was that some respondents regarded the sedative side effect as supportive.
In a German general population survey, preference for psychotherapy seemed primarily based on the ideas that this treatment modality provides an opportunity for personal exchange and that the cause of the problem can be solved (Angermeyer et al., 1993). Respondents who were negative about psychotherapy tended to prefer alternative treatment options (e.g. lifestyle changes and talking to friends), 13% thought that psychotherapy was not effective and 8% thought that problems would increase by talking about them. These concerns were also raised in focus groups among recently depressed primary care patients (Cooper-Patrick et al., 1997)

Three studies described factors associated with preferences among depressed primary care patients. In the study of Dwight-Johnson et al. (2000) female gender, ethnicity (African American people compared with white people), greater knowledge about counselling, paid sick leave and no recent antidepressant treatment were associated with a preference for counselling. Bedi et al. (2000) described those preferring counselling as tending to have a more middle-class profile. In addition, they found that those who preferred antidepressants were more likely to have a more severe depressive illness. Simpson et al. (2000) observed that patients with any kind of preference were less likely to be married, had more minor psychiatric disorders and reported more problems, compared with patients who accepted randomisation.

In the general population surveys, respondents' characteristics positively associated with preference for psychotherapy or counselling were: female gender or female gender and being single (McKeon & Carrick., 1991; Churchill et al., 2000); being highly educated (Angermeyer & Matschinger, 1999); being of upper and middle social class, living in a city (McKeon & Carrick., 1991); having personal experience with psychotherapy or counselling (Angermeyer & Matschinger, 1999; Churchill et al., 2000); believing that depression can be a serious illness and that 20% of people suffer from depression some time in their life (Churchill et al., 2000). Respondents' characteristics positively associated with preference for antidepressants or psychotropic drugs were: having personal experience with psychotropic drugs (Benkert et al., 1997) living outside the city, being female and married (McKeon & Carrick., 1991), and being older (McKeon & Carrick., 1991; Zeitlin et al., 1997).

4.3.3 Clinical trials incorporating patients' preferences

Dwight-Johnson et al. (2001) explored whether quality improvement programs for depression addressed patients' preferences for treatment. Patients' preferences were measured at baseline and were discussed and supported by health care personnel as part of the quality improvement intervention. It was found that more patients entered treatment and more patients received the preferred treatment in the quality improvement intervention compared with usual care patients. Furthermore, in the usual care group it was found that patients who preferred counselling but did not receive it were likely to go without treatment altogether.

Two trials in this review used a partially randomised patient-preference design (Bedi et al., 2000; King et al., 2000): patients who did not accept randomisation were given the treatment of their preference. Neither of the studies found significant differences in outcome scores between participants who were randomised to psychotherapy and those who chose it, nor was the preference option associated with higher rates of follow up. Both studies also measured satisfaction with treatment and did not observe significant differences in satisfaction with treatment between the preference groups and the randomised groups.

4.4 Conclusions

1. Which treatment do depressed and non-depressed people prefer? In all studies psychotherapy and counselling were preferred to antidepressants.
2. What are the underlying assumptions and the associated factors? Psycho therapy was preferred because it was assumed to provide an opportunity for personal exchange and to solve the problem underlying the depression. Antidepressants were often seen as addictive. Using psychotropic drugs was accompanied by more fear of losing control than using drugs for physical diseases. Female gender, former experience with psychotherapy, and a middle class profile were in several studies associated with a preference for psychotherapy; experience with psychotropic drugs, and old age were predictors of preference for antidepressants.
3. Do patients' preferences affect treatment compliance and outcome in clinical trials? When health care personnel supported patients' preferences as part of a quality improvement intervention programme, patients could be encouraged to use the treatment that was most suitable for them. In addition, it was found that patients who strongly preferred counselling, but did not receive it were likely to go without treatment altogether. In two partially

randomised patient-preference trials, preference did not predict outcome. Yet, in these studies all patients were offered a choice; many of them (mostly those preferring psychotherapy) would not have entered the study if they were to accept randomisation i.e. antidepressant medication.

4.5. Discussion

The finding that psychotherapy and counselling were preferred to antidepressant medication was strikingly unequivocal. However, considerable differences were found in the degree to which the preferences for psychotherapy over antidepressants were expressed. Interpretation of this variation is difficult, because of methodological variation among studies. For example, the amount of information provided about the treatment options, the way questions were formulated and the timing of the questions differed substantially. Literature on decision-making processes has demonstrated that methods of assessment and framing of the questions highly affect preferences (Mayhorn et al., 2002; Stiggelbout et al., 2001).

Few studies paid attention to assumptions underlying preferences . Preferences were quite often affected by a lack of information and the arguments used can be contradicted: psychotherapy cannot resolve the cause of depression, antidepressants are not addictive and the effectiveness of counselling has not been sufficiently proven. Yet, the existence of these incorrect assumptions in depressed patients and in the general public underlines the need for the provision of adequate information not only by physicians to individual patients, but also by professional organisations to the general public.

It is important to notice that preferences of patients who are not properly informed about the treatment options cannot be used for studying medical decision- making. When specific preference assessment techniques are used, for example in oncology, clear descriptions are given of the different treatment options, their side effects and possible outcomes. Although some studies in this review presented a complete description of the treatment options (e.g. Dwight-Johnson et al., 2000) no preference assessment techniques such as utility assessment or probability trade-off methods were used (Stiggelbout et al., 2001; Froberg & Kane, 1989).

In the studies exploring patient characteristics associated with preferences, it was found that patients who already received psychotherapy or medication tended to prefer this same treatment. This phenomenon has been observed in other fields of medical decision-making and is explained by cognitive dissonance reduction: subjects make their preferences agree with the decision that

was made (Stiggelbout et al., 2001). Therefore, when studying preferences, it is important to distinguish between patients who have already experienced one of the treatment options and those who have not.

Several trials of this review integrated patients' preferences into a clinical trial. The data of Dwight-Johnson et al. (2000) were obtained from the Partners in Care study (Wells, 1999). This study resembles the traditional RCT, but after randomisation, different intervention protocols are allowed depending on patient preferences, implicitly assuming that preferences are important. The aim of this design is to enhance generalizibility of findings to usual care practice and not to study the role of preference as such. Two studies used a partially randomised preference design. The main reason for using this design was to be able to recruit more representative patients, especially because strong preferences among some patients existed. In the preference arms of the studies, many more patients chose psychotherapy or counselling. This design can be criticised because of several methodological difficulties, the most important being that unobserved confounders may have occurred (TenHave et al., 2003). Results should therefore be interpreted with caution.

Some findings of this review can be applied to clinical practice. There is no doubt that providing information and discussing the assumptions underlying the preferences is a necessary approach before starting therapy. Sometimes it is necessary to involve family or friends, as they may strongly influence a patients' opinion. As a substantial percentage of depressed patients prefer psychotherapy after being informed, short-term psychotherapy should be made accessible in primary care, particularly as previous studies have shown that most patients do not wish a specialty mental health referral (McKeon &Carrick, 1991)

In future research, attention should be paid to the validation of preference measures so that comparability between studies is enhanced (Wensing & Elwyn, 2003; Thornett, 2001; Cooper et al., 2000). Utility assessment techniques may be applied to study the implications of the preferences on the organisation of care.

CHAPTER 5

Feasibility and barriers to providing Interpersonal Psychotherapy (IPT) for late-life depression in general practice

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Abstract

Objective To explore the feasibility and barriers to introducing Interpersonal Psychotherapy (IPT) for the treatment of depressed elderly patients in general practice.

Method Feasibility data were recorded in a randomised clinical trial comparing IPT with usual general practitioner (GP) care. Depressed patients were identified by means of a two-stage screening procedure among elderly patients visiting their general practitioner. Included were all patients (≥55 years) who met the DSM-IV criteria for major depressive disorder. Feasibility was assessed by recording motivation and evaluation of patients, GPs and therapists. Organisational barriers were assessed.

Results Of the 205 eligible patients, 143 (70%) entered the study, and of the 69 patients who were offered IPT, 77% complied with the treatment. All four specialist mental health organisations that were contacted supported this intervention. The majority of the participants evaluated the intervention positively. Organisational barriers were lack of room in some general practices and time and financial restraints for psychotherapists working in private practices.

Conclusions Providing IPT by mental health workers in general practice is feasible, as long as the practices have room for the therapists and financial barriers can be overcome. Consolidation may be achieved by making this intervention available through practice nurses or community psychiatric nurses who deliver IPT as part of a more comprehensive depression management programme.

5.1 Introduction

Depression among elderly primary care patients is common. Of the older patients who visit a primary care clinic 5-10% has a depressive disorder (Lyness et al., 1999; Schulberg et al., 1998). Depression causes suffering and is associated with serious disability, reduced quality of life and general functioning. The course of depression is often chronic or recurrent (Cole et al., 1999; Beekman et al., 2002). Delivering efficacious treatments is of major importance for this group of patients.

Although research on depression treatment in older primary care patients is limited (Freudenstein et al., 2001), antidepressant drugs and some forms of psychotherapy are both considered to be evidence based therapies, as they were effective in older secondary care patients (Baldwin et al., 2003). Yet, it has consistently been found that the majority of depressed elderly patients in primary care do not receive adequate depression treatment (Young et al., 2001). When depression treatment is started, usually antidepressants are offered. Because older patients are more sensitive to side-effects and interactions with other medication, psychotherapy may be given as an alternative to drug treatment. However, evidence based psychotherapy is not available in most general practices, while referrals to secondary care are frequently not completed by older patients (Schulberg et al., 2001). Therefore, few older patients receive psychotherapy. Introducing an easily accessible psychotherapy in general practice may contribute to the improvement of depression care for older patients.

Interpersonal psychotherapy (IPT) seems to be a suitable form of psychotherapy to be delivered to older primary care patients. Its efficacy has been proved (Thase et al., 1997), and it has been studied both in older patients (Reynolds et al., 1999) and in adult primary care patients (Schulberg et al., 1996). Furthermore, therapists with different therapeutic backgrounds can learn this therapy relatively easily (Weissman et al., 2000). Despite the favourable results of IPT in research populations, the dissemination to general practice is surprisingly limited. To explore the implementation potential of IPT, it is important to study the feasibility and barriers to introducing this therapy in normal life (general) practice.

This paper focuses on the feasibility of providing IPT for depressed elderly patients in general practice. Data on feasibility were recorded in a randomised clinical trial comparing IPT with care as usual provided by the general practitioner (GP). Because there are no strict quantitative criteria to define a positive or negative result of a feasibility study, the study consists of a description of the feasibility and barriers to the introduction of IPT in general practice.

5.2 Methods

The study was conducted in 12 general practices in Amsterdam and surroundings, based on a protocol approved by the Medical Ethics Review Committee of the VU University Medical Centre in Amsterdam.

Patients. The patients were recruited by means of a two-stage screening procedure in the general practices. All patients of 55 years or older who visited their general practitioner (GP) were sent a depression screening questionnaire: the 15-item Geriatric Depression Scale, GDS-15 (Sheikh & Yesavage, 1986). Patients who scored 5 or more on the GDS-15, were contacted by telephone by one of the research assistants and were invited to participate in the diagnostic procedure. The diagnostic instrument used to assess depressive disorder was the mood module of the PRIMary care Evaluation of Mental Disorders, PRIME-MD (Spitzer et al., 1994). Exclusion criteria were: receiving treatment for depression at the time of screening, insufficient command of the Dutch language or severe cognitive impairment.

Therapists and general practitioners. Specialist mental health centres and private psychotherapists' practices were approached for participation. Training in standardized IPT was given in a 2-day course, followed by group supervision sessions every two weeks during participation in the trial. General practices which could be reached within half an hour from the workplace of the mental health workers were contacted by telephone and invited to participate.

Intervention. IPT is a structured, time-limited therapy (Weissman et al., 2000). In the initial phase of the treatment the depressive symptoms are explored and psycho-education about depression is given. The interpersonal context of the patient is explored and the depressive symptoms are linked to recent interpersonal events. There are four possible treatment focuses to be distinguished: complicated grief, interpersonal conflict, role-transition and interpersonal deficit. One of these focuses is chosen. The nature of this specific interpersonal event is explored and accompanying emotions are elicited. The patient is supported in considering and working out possible solutions. During the last sessions, the therapy is evaluated, and attention is paid to the prevention of relapses. For use in general practice the number of IPT sessions was reduced from the usual 14 to 10. We assumed that with this number of sessions drop-out would be less likely. We also assumed that a less intensive type of treatment would be sufficient, because of the less severe nature of major depressive disorders in general practice (Schwenk et al.,1998). The aim was to complete the therapy within five months.

Feasibility. To asses the motivation of the participants, data concerning the

recruitment of patients, therapists and GPs were collected. The number of IPT sessions completed, drop-out rates and drop-out reasons were recorded by the therapists. Additionally, the intervention was evaluated by all participants. Interviews with the patients were carried out by independent and specifically trained interviewers. At six months follow-up, patients were asked to evaluate the intervention by means of the 8-item Client Satisfaction Questionnaire (De Brey, 1983). At the end of the project, the therapists and the participating GPs were sent a questionnaire containing specific and open-ended questions about the intervention. Furthermore, organisational barriers and facilitating factors were recorded during the project.

5.3 Results

5.3.1 Motivation of the participants

Patients. The GDS-15 was presented to 6.719 patients. Of them, 4.143 patients (62%) could be fully screened (GDS-15 and PRIME-MD if the GDS-15 score was ≥5). Of the 205 eligible patients with current major depression, 143 (70%) gave informed consent and therefore had a positive or at least neutral attitude towards IPT. The research population of this feasibility study consisted of the 69 patients who were allocated to the IPT condition. Table 5.1 presents the characteristics of these patients. The mean number of treatment sessions was eight. Of the 69 patients who started the therapy 47 (68%) completed 10 sessions. 6 patients (9%) terminated the therapy earlier while the therapist agreed that they did not need to continue any longer. Thus, 77% of the patients were compliant with the therapy.

General practices. Of the 18 general (mostly group) practices that were approached, 6 refused. Lack of available room for the therapists was mentioned as the main barrier by representatives of four practices. One objected to the screening procedure and one saw no need for this intervention.

Private psychotherapy practices, specialist mental health centres and mental health workers. The two psychologists' private practices that were approached, were interested in IPT, but could not join the project, because of financial and organisational reasons. Specialist mental health centres were motivated, as long as the extra workload of the therapists was limited. Four centres provided therapists. The geriatric teams of these organisations received training in IPT, and it turned out that the majority of therapists were interested in joining the research project. Nine psychiatric nurses and six psychologists participated in the study. Supervision was provided at the workplace of the therapists and was well attended.

Table 5. 1 Baseline characteristics of patients allocated to the IPT intervention

Characteristics	IPT (n=69)
Sociodemographic	
Mean (SD) age, years	68.4 (8.1)
Female (%)	48 (70)
Married or living together (%)	33 (48)
Level of Education (%) Low Intermediate High	 23 (33) 27 (39) 19 (28)
Clinical	
MADRS, mean (SD)	19.4 (7.9)
CGI-s , median (SD)	3.3 (1.3)

Note: MADRS=Montgomery Asberg Rating Scale; CGI-s=Clinical Global Impression severity scale.

5.3.2 Evaluation of the intervention

Patients. Patient satisfaction was measured by means of the CSQ-8, which was completed by 54/69 patients. The mean item score on this scale (ranging from 1 to 4) was 3.0 (SD 0.6). which represents a very positive evaluation.

General practitioners. Patients of 22 GPs received IPT, and all of these 22 GPs returned the evaluation questionnaire. Their evaluation of IPT was positive, mainly because of its time-limited, practical and structured nature. All but one of the GPs thought that this intervention lowered the barrier to providing adequate care for a group of elderly patients, who do not want to be referred to specialist mental health facilities. These same GPs stated that they would use this intervention if it were available after the end of the research project.

Therapists. The participating therapists were positive about working within the general practice. Most of them were used to doing outreaching work, and the visits to the GP could be integrated well into their schedule. Of the 15 therapists, 11 reported that they occasionally needed extra time and flexibility to find office space, and one found this a very unpleasant complication. Therapists were positive about the structure and strategies provided by the IPT protocol.

5.4 Discussion

In this study we explored the feasibility and barriers to the introduction of IPT for depressed elderly patients in general practice. Of the 205 eligible patients, the majority (70%) was motivated to participate, and 53 patients (77%) who were offered IPT, complied with the therapy. All four specialist mental health organisations that were contacted joined the project, and the majority of the mental health workers and general practitioners were welll-motivated and evaluated the intervention positively afterwards.

The percentage of compliant patients (77%) is high compared to the compliance found in treatment with antidepressants in general practice. It has been found that more than 50% of the patients stop their medication within three months (Lawrenson et al., 2000) Schulberg et al. (1996), who also used a screening procedure to recruit patients, and who compared IPT with antidepressant drug treatment for adult patients in primary care, found higher drop-out rates in their IPT group: 14% failed to appear at the start, and 50% did not complete all 16 weekly sessions. The number of treatment sessions in our project was lower and in general, elderly patients tend to have relatively low drop-out rates in treatment for depression (Bech et al., 2003; Salzman, 1995).

The percentage of eligible patients who were motivated for the intervention (70%) cannot be generalised as such to all older primary care patients, because we were not able to screen the whole target population. Probably, the percentage of refusals would be higher among the depressed non-completers of the screening procedure. Additionally, our population was primarily from (sub)urban regions. In the survey of McKeon, living in a city was positively associated with a preference for psychotherapy (McKeon & Carrick, 1991). Thus, the estimate of 70% is probably optimistic, but notwithstanding that we can conclude that from the perspective of many older patients in general practice, IPT is a feasible and welcome treatment option.

GPs and therapists were not randomly selected and those who participated probably represent the more motivated professionals. However, our findings give an indication that at least a substantial percentage of therapists and GPs is interested in this intervention and that, once on board, they evaluate it positively.

Some findings may not be generalisable to other countries. Patients did not have to pay for their therapy. Therefore, we do not know to what extent financial barriers may influence uptake in real life practice in countries with a different financial organisation of the health service. Training and supervision in IPT may also be more difficult to organise in other places, but there is an International Society for IPT, and in Europe there is an active group of initiators who

share knowledge and experiences in IPT research, training and supervision (www.interpersonalpsychotherapy.org).

Organisational changes to implement an intervention can only be made if the intervention is feasible ànd effective in the population under study. IPT was more effective than usual GP care in reducing the number of patients with major depressive disorder (Van Schaik et al., 2006). This finding was more pronounced in patients with moderate to severe depression at baseline, than in patients with mild depression. Determinants of treatment outcome, other than initial depression severity, will be explored. The effectiveness of depression teatment as a whole can probably be improved when patients can choose or switch between interventions, and combination therapies can be given. In two recent studies, IPT and Problem Solving Therapy (PST) were delivered as part of depression management programmes for older primary care patients (Bruce et al., 2004; Unützer et al., 2002). In these programmes, treatment was tailored to the needs of individual patients, and switching and combining of therapies was possible. The results of these studies were positive.

The present study shows that it is feasible to make IPT available in real life general practice for older patients with major depression as long as the practices have room for the therapists and financial barriers can be overcome. This implies that an important gap in the depression care for older patients can be filled. Because it is feasible to organise the delivery of IPT in general practice, and because the effectiveness of depression management programmes has been proved, there are grounds to support the implementation of IPT as part of depression management programmes for patients who prefer psychotherapy (Van Schaik et al., 2004) or who do not benefit from antidepressant drug treatment (as a monotherapy). Future research should focus on the fine-tuning of the intervention (e.g. optimal number of sessions, comparing IPT with PST) and on identification of patient characteristics that modify treatment effectiveness.

CHAPTER 6

Interpersonal Psychotherapy for elderly depressed patients in primary care

Van Schaik DJF, Van Marwijk HWJ, Adèr HJ, Penninx BWJH, Van Dyck R, De Haan M, Van der Kooij K, Van Hout HPJ, and Beekman ATF. (2006). American Journal of Geriatric Psychiatry. In press.

Abstract

Objective Interpersonal psychotherapy (IPT) is recommended in most depression treatment guidelines, but little is known about its effectiveness in real-life practice. This study investigates whether IPT, delivered by mental health workers to elderly patients with major depressive disorder, is more effective than usual general practitioners' care (CAU).

Methods A pragmatic randomised controlled trial was conducted in which 143 patients were allocated to IPT (10 sessions) or to CAU. PRIMary care Evaluation of Mental Disorders (PRIME-MD) and Montgomery Åsberg Depression Rating Scale (MADRS) assessments were used as primary outcomes.

Results IPT was significantly more effective in reducing the percentage of patients with a diagnosis of depression (PRIME-MD), but not in inducing remission (MADRS <10). Among treatment completers, IPT was superior in improving social and overall mental functioning. A post hoc analysis revealed that IPT was superior to CAU in moderately to severely depressed patients, but not significantly so in mildly depressed patients.

Conclusions IPT was more effective than CAU for elderly patients with moderate to severe major depressive disorder in general practice. Future research should focus on determinants of treatment outcome.

6.1 Introduction

Depression among elderly primary care patients is common. Of the older patients who visit a primary care clinic 5-10% has a depressive disorder (Lyness et al., 1999; Schulberg et al., 1998). If depression in the elderly remains untreated, it increases mortality from co-morbid medical conditions or suicide, and increases service utilization and demands on caregivers (Charney et al., 2003; Penninx et al., 2000). Delivering efficacious treatments is of major importance for this group of patients.

There is evidence of sub-optimal treatment for elderly patients with major depression in primary care, despite the existence of several effective treatment options (Baldwin et al., 2003). Antidepressant drugs are mostly the treatment of first-choice when a specific depression treatment is indicated. Patients who do not benefit from this medication may switch to psychotherapy, as can patients who prefer psychotherapy (Van Schaik et al., 2004). However, psychotherapy is mostly not available in general practice, and older patients often resist to referral to specialized mental health facilities (Bartels et al., 2004). Therefore, providing easily accessible psychotherapy within primary care may contribute to the improvement of depression care for the elderly.

Both the format and the content of Interpersonal Psychotherapy (IPT) are especially suitable for elderly patients (Miller et al., 1997). However, dissemination of IPT is limited, and little is known about its effectiveness for older patients in real-life general practice. Before implementation can be further promoted, the effectiveness of this intervention should be studied more extensively.

This article examines the effectiveness of IPT, delivered by mental health workers within general practice to elderly patients with major depressive disorder. The research question is whether IPT is more effective than usual GP care (CAU) in reducing depressive symptoms and in increasing general functioning.

6.2 Methods

This randomised controlled trial was based on a protocol approved by the Medical Ethics Review Committee of the VU University Medical Centre in Amsterdam. It was conducted in 12 general practices in Amsterdam and surroundings. Six other practices were approached, but refused participation, mostly because they had no office facilities for the therapists in the practices.

6.2.1 Sample and interventions

Participants were recruited from February 2002 to July 2003 by means of a two-stage screening procedure. We sent a depression screening questionnaire, the 15-item Geriatric Depression Scale, to individuals of 55 years or older, who had recently visited the GP (GDS-15, range 0-15, higher scores indicate more depressive symptoms (Sheikh & Yesavage, 1986). A research assistant contacted respondents, who scored 5 or more on the GDS-15, and invited them for further diagnostic examination. If they consented, the research assistant administered the mood module of the PRIMary care Evaluation of Mental Disorders (PRIME-MD) to asses a diagnosis of depressive disorder (Spitzer et al., 1994). Excluded were respondents who had: (i) treatment for depression at the time of screening, (ii) insufficient understanding of the Dutch language or (iii) severe cognitive impairment (Mini-Mental State Examination score of <18). Eligible patients were informed about the study, and received written explanation. Those who signed informed consent were randomly allocated to either IPT or CAU. An independent research assistant performed randomisation per practice at the patient level by using a table of random numbers (Pocock, 2002). Blocking by practice (blocks of four) was used to ensure that comparison groups were of approximately the same size per practice.

Interpersonal psychotherapy. Six psychologists and nine psychiatric nurses provided IPT. All therapists had worked for more than five years in mental health care, and 13 had two or more years of experience in working with elderly patients. None of them were IPT therapists. Training in standardized IPT was given in a 2-day course, followed by group supervision sessions every two weeks during a period of one year, after which the frequency of the supervision sessions was reduced to once a month. All therapy sessions were audiotaped, and the tapes were used for individual feedback and for review purposes in the group supervision sessions. IPT is a structured, time-limited therapy, specifically developed for the treatment of depressive disorder; its efficacy has been demonstrated, also in the elderly (Reynolds et al., 1999; Thase et al., 1997). The treatment protocol is described in a manual, and therapists with different therapeutic backgrounds can learn this therapy relatively easily. In the initial phase, the depressive symptoms are explored and psycho-education about depression is given. The interpersonal context of the patient is explored and depressive symptoms are linked to recent interpersonal events. There are four possible treatment focuses: complicated grief, interpersonal conflict, role-transition and interpersonal deficit. One of these focuses is chosen. The nature of this specific interpersonal event is explored and accompanying emotions are elicited. The patient is supported

in considering and working out possible solutions. In closing, the therapy is evaluated, and attention is paid to the prevention of relapses. For use in general practice we reduced the number of IPT sessions from 14 to 10, which had to be completed within five months. We assumed that with this number of sessions, drop-out would be less likely (Browne et al., 2002) and that a less intensive type of treatment would be sufficient, since major depressive disorders are in general less severe in primary care (Schwenk et al., 1998). When a patient was allocated to the IPT intervention, the GP was informed and asked not to prescribe any antidepressants or to refer for psychotherapy or counselling.

Care as usual. GPs were not informed about patients who were included in the care as usual arm of the study, except when they were suicidal.

6.2.2 Outcome

Follow-up assessments were carried out at two and six months after the baseline interview. The primary endpoint with respect to effectiveness was the proportion of patients achieving remission of depression at six months follow-up. Remission was defined as having a score of less than 10 on the Montgomery Åsberg Depression Rating Scale (MADRS, range 0-60, higher scores indicate higher severity of depression (Montgomery & Asberg, 1979; Hawley et al., 2002). Furthermore, analyses were done on the proportion of patients who had a diagnosis of depression (PRIME-MD mood module) and on changes in the mean MADRS and GDS-15 (self-report) scores. The secondary outcome, general functioning, was measured using the Medical Outcome Study 36-item Short Form Health Survey (SF-36, range 0-100, higher scores indicate better functioning; Ware & Gandek, 1998). The independent interviewers were trained in a 1½-day course. Halfway through the project an additional training day was organised, and during the whole study, feedback was given based upon recorded audiotapes of interviews. Usual GP care was monitored using diaries about health service use, recorded by the patients.

6.2.3 Analysis

We expected 50% remission in the intervention group versus 25% in the reference group. This expectation was based on findings of other psychotherapy intervention studies on the treatment of major depression in adults in primary care (Mynors-Wallis et al., 1995; Schulberg et al., 1996). To detect this risk difference (RD) of 25% (with alpha=.05 and beta=0.80) 60 patients per arm were needed (Pocock, 2002). When accounting for a drop-out percentage of 10 %, a total of 140 patients should be selected.

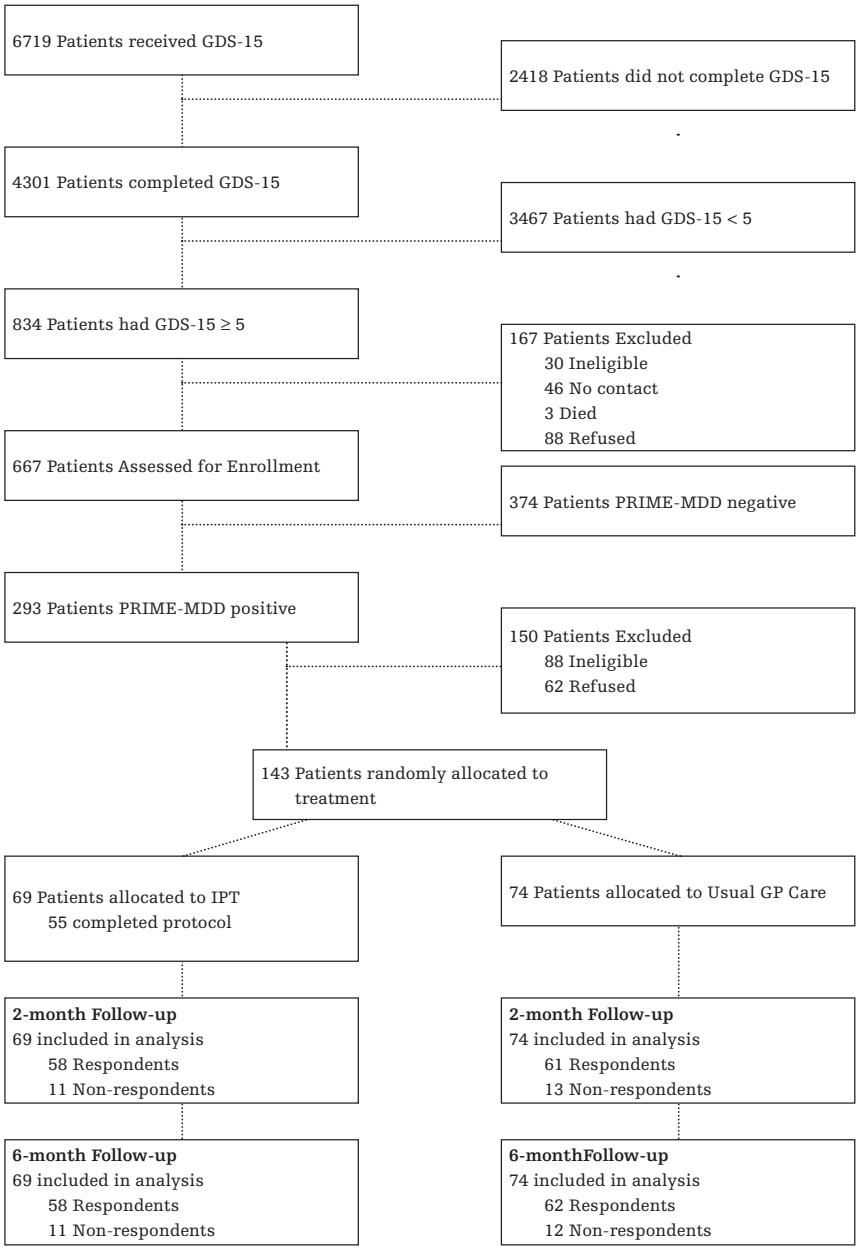
Data-analysis consisted of descriptive statistics, including percentages for binary outcomes and means and SDs for continuous outcomes. Between group differences in binary outcome measures were analysed using chi-square tests at different time-points. These analyses were based on available data. When a significant difference was found, we performed sensitivity analyses, assuming that all patients of whom the data were missing had not improved. For these analyses, SPSS for Windows, version 11.0 was used. Effect sizes (defined as the difference between the mean end scores of the intervention and control groups, divided by the pooled standard deviation of the end scores (standardised mean differences) were calculated using Revman (version 1.0.2. The Cochrane Collaboration). Random coefficient analysis was performed on the continuous outcome data to achieve more efficient statistical inference and enhance power of the analyses. We used intention to treat analysis, by including all patients who were randomly assigned in these analyses. Per protocol analyses were also performed. Patients who completed six or more sessions of IPT, and all patients in the usual GP care condition were considered treatment completers. These analyses were carried out using MLwiN (version 1.1) statistical software (Rasbash et al., 2000).

Since it has been found that specific interventions, such as short-term psychotherapy, may be more effective than control conditions in patients with moderate to severe depression (Angst et al., 1993; Elkin et al., 1995), post hoc analyses were performed, taking account of the baseline MADRS score dichotomised around a score of 21 (Mottram et al., 2000).

6.3 Results

Figure 6.1 shows that 6719 persons were approached to identify 293 patients with major depressive disorder. Of these, 88 (30%) were ineligible, mainly because of ongoing treatment for depression at the time of screening. Of the eligible patients, 143 (70%) agreed to participate. Participants were on average 2.9 years ($t_{[202]} = -2.03$; p=0.04) younger than non-participants. There were no significant differences in gender and severity of depression between participating and non-participating patients. The intervention and control group did not differ on demographic and clinical characteristics (Table 6.1). In the IPT group 11 patients (16%) and in the CAU group 12 patients (16%) dropped out before six months follow-up.

Figure 6.1. Flow diagram



Note: PRIME-MDD = PRIME-MD mood module

Table 6.1. Baseline characteristics of included patients

Sample characteristics	IPT (N=69)	Usual GP care (N=74)	Tests $X^2_{[df]}$ or $F_{[df]}$	p
Age, mean (SD)	68.4 (8.1)	67.5 (9.2)	$2.18_{[1,141]}$	0.54
Women	48 (70)	51 (69)	$0.01_{[1]}$	0.93
Married or living together	33 (48)	36 (49)	$0.03_{[1]}$	0.86
Level of Education Low Intermediate High	 23 (33) 27 (39) 19 (28)	 32 (43) 25 (34) 17 (23)	$1.49_{[2]}$	0.47
MADRS, mean (SD)	19.4 (7.9)	19.3 (8.6)	$0.48_{[1,141]}$	0.95
GDS-15, mean (SD)	8.5 (2.5)	8.5 (2.5)	$0.03_{[1,141]}$	0.69
CGI, mean (SD)	3.3 (1.3)	3.2 (1.4)	$1.21_{[1,137]}$	0.68
≥ 3 depressive episodes	21 (43)	23 (43)	$0.01_{[1]}$	0,96
Onset before 50 years	36 (52)	46 (63)	$1.71_{[1]}$	0.19
SF 36 physical summary score, mean (SD) SF-36 mental summary score, mean (SD)	39.4 (11.2) 37.2 (10.8)	41.2 (11.0) 37.1 (11.7)	$0.02_{[1,141]}$ $0.24_{[1,141]}$	0.33 0.94
MMSE, mean (SD)	26.3 (2.1)	26.4 (2.0)	$0.12_{[1,141]}$	0.77
Number of chronic illnesses, mean (SD)	5.3 (2.8)	5.3 (2.9)	$0.11_{[1,122]}$	0.99

Note: Data are presented as N (%), unless otherwise specified. SD: standard deviation.

Patients in the intervention group (N=69) received on average eight (out of 10) sessions of IPT. A total of 55 (80%) patients completed six or more sessions of IPT, and were therefore included in the completer analysis. A total of 80 patients, 39 (56%) from the IPT group and 41 (55%) from the care as usual group, completed the medical consumption diaries over the first six months after inclusion. According to these diaries four patients in the care as usual group received counselling, and one used antidepressant drugs. In the IPT group, no antidepressant drug use was recorded. The mean number of contacts with the GP was 3.9 (SD 3.5) in the IPT group and 5.0 (SD 6.5) in the CAU group ($t_{[78]} = -.92$; p=0.36).

From Table 6.2 it can be seen that there was a significant difference in the proportion of patients with no diagnosis of major depression at six months follow-up. Assuming that all missings were PRIME-MD positive (a very conservative assumption), the difference was 17% (50.7% versus 33.8%) and still significant. This implies a number needed to treat of six. No difference was found in the percentage of patients with response (50% reduction in MADRS score) or complete remission (MADRS score < 10).

Table 6.2. Diagnosis of Depression and Remission

	IPT	Usual GP care	$X^2_{[df]}$	p
No Diagnosis of Depression (PRIME-MD mood negative)				
2 months	22 (37.9%) 22 (31.9%)a	22 (36.1%) 22 (29.7%)a	$0.04_{[1]}$ $0.08_{[1]}$	0.83 0.78
6 months	35 (60.3%) 35 (50.7%)a	25 (40.3%) 25 (33.8%)a	$4.80_{[1]}$ $4.21_{[1]}$	0.03 0.04
Response (50% reduction MADRS)				
2 months	7 (11.3%)	6 (9.2%)	$0.15_{[1]}$	0.70
6 months	16 (27.6%)	18 (29.0%)	$0.03_{[1]}$	0.86
Remission (MADRS < 10)				
2 months	8 (12.9%)	7 (10.8%)	$0.14_{[1]}$	0.71
6 months	19 (32.8%)	20 (32.3%)	$0.00_{[1]}$	0.95

Note: Data are presented as N (%). a: assuming all missings had diagnosis.

Table 6.3 presents the results of the continuous MADRS and GDS-15 scores. A positive value of the b, the regression coefficient of the time versus treatment interaction, indicates superiority of the intervention over the control condition. No significant differences were seen on either measure. The effect size, calculated on available cases (n= 58 in IPT group, n=62 in CAU group) was, based on the MADRS data: –0.11 (95% CI: -0.47 to 0.24), and on the GDS data: –0.03 (95% CI: -0.39 to 0.33).

Table 6.3. Depression severity over time

	IPT	Usual Care	Intention to treat			Completers		
			b	$t_{[df]}$	p	b	$t_{[df]}$	p
MADRS, mean (SD)								
Baseline	19.4 (7.9)	19.3 (8.6)						
2 months	17.1 (7.5)	19.4 (8.7)	2.97	$1.92_{[125]}$	0.06	2.87	$1.91_{[118]}$	0.06
6 months	13.9 (7.9)	14.9 (9.6)	1.56	$0.99_{[118]}$	0.32	1.78	$1.06_{[113]}$	0.29
GDS-15, mean (SD)								
Baseline	8.5 (2.5)	8.6 (2.5)						
2 months	7.4 (2.9)	7.6 (3.0)	0.19	$0.36_{[116]}$	0.72	-0.22	$0.43_{[110]}$	0.67
6 months	5.8 (3.5)	5.9 (3.5)	-0.08	$0.15_{[118]}$	0.88	-0.22	$0.42_{[113]}$	0.67

Note: SD: standard deviation; b: regression coefficient of the time x treatment interaction, computed in random coefficient analysis.

Table 6.4 presents the results of the secondary outcome measure, the SF-36. In addition to the main physical and mental component summary scores, we present the social functioning subscale separately, because IPT focuses on improving social functioning. A negative b indicates that the intervention was more effective than CAU. A superior effect of the IPT intervention could not be demonstrated in the intention to treat analysis. However, in the completer analysis, IPT proved to be more effective than usual GP care on the mental component summary score and on the social functioning subscale.

Table 6.4. SF-36 results

	IPT	Usual Care	Intention to treat			Completers		
			b	$t_{[df]}$	p	b	$t_{[df]}$	p
SF-36 physical, mean (SD)								
Baseline	39.4 (11.2)	41.2 (11.0)						
6 months	39.7 (13.2)	41.7 (11.4)	0.94	$0.68_{[118]}$	0.50	0.74	$0.52_{[113]}$	0.60
SF-36 mental, mean (SD)								
Baseline	37.2 (10.8)	37.1 (11.7)						
6 months	42.4 (11.4)	39.4 (11.1)	-3.41	$1.77_{[118]}$	0.08	-4.22	$2.15_{[113]}$	0.03
SF-36 social, mean (SD)								
Baseline	58.0 (27.8)	60.5 (27.1)						
6 months	69.0 (24.8)	64.7 (25.8)	-7.14	$1.43_{[118]}$	0.15	-10.22	$1.98_{[113]}$	0.05

Note: SD: standard deviation; b: regression coefficient of the time x treatment interaction, computed in random coefficient analysis.

In post hoc analyses, the differential effect of the categorical MADRS baseline score (<21, yes/no) was explored. Table 6.5 shows that in the subgroup of patients with a baseline MADRS score of 21 or more, significantly more patients had no diagnosis of depression anymore in the IPT group than in the CAU group (RD = 27.1%), whereas in patients with a low initial MADRS score, the difference was smaller (RD = 8.8%) and not significant.

This differential effect could also be demonstrated by the GDS data: In the subgroup of patients with an initial MADRS score of ≥21, the IPT group improved more on the GDS-15 than the usual care group, while in patients with an initial MADRS score of <21, the care as usual group did better. To test the significance of this differential effect, we included the baseline MADRS score as a binary variable into the GDS-15 regression equation, and found that the b of the interaction term of the categorical MADRS versus time (6 months) and treatment was positive and significant.

Table 6.5. Differential effect of initial depression severity on treatment outcome (at 6 months)

	IPT	CAU	$X^2_{[df]}$		p
No diagnosis of depression, N (%)					
Baseline MADRS ≥ 21	15 (60.0%)	9 (31.0%)	$4.56_{[1]}$		0.03
	15 (53.6%)a	9 (26.5%)a	$4.75_{[1]}$		0.03
Baseline MADRS <21	20 (60.6%)	16 (48.5%)	$0.98_{[1]}$		0.32
	20 (48.8%)a	16 (40.0%)a	$0.63_{[1]}$		0.43
	IPT	CAU	b	$t_{[df]}$	p
GDS, mean (SD)				$2.07_{[118]}$	
Baseline MADRS ≥ 21	6.4 (3.4)	7.5 (3.9)	1.55		
Baseline MADRS <21	5.4 (3.5)	4.5 (2.3)			0.04

Note: a: assuming all missings had diagnosis. SD: standard deviation; b: regression coefficient of the time x treatment x binary variable MADRS < 21 (yes/no) interaction, computed in random coefficient analysis.

6.4 Discussion

The aim of this randomised controlled trial was to explore the effectiveness of IPT for depressed elderly patients in general practice. We expected that treatment effects in our pragmatic trial would be demonstrable, but smaller than effects in a comparable efficacy trial. We found that IPT was indeed more effective than usual GP care in reducing the number of patients with a diagnosis of major depressive disorder post treatment (RD 17%). However, many patients reported residual symptoms. Remission rates were relatively low (32-33%) and did not differ between the groups. There were also no significant differences in mean scores on the MADRS, GDS-15 and SF-36 scales. Among treatment completers, IPT was superior in improving social and overall mental functioning. A post hoc analysis revealed that severity of the index depression had a differential effect on treatment outcome: the effect of IPT was more pronounced in those with moderate to severe depression (MADRS ≥21) at baseline.

6.4.1 Comparison with other studies

Two recent primary care studies on depression care enhancing interventions for elderly patients, reported comparable low percentages of remission (Bruce et al., 2004; Unützer et al., 2002). Remission percentages in adult primary care patients were found to be higher, ranging from 50-67% (Dawson et al., 2004). In both younger and older adults, the effect sizes of depression management programs in general practice are relatively low. In a recent review of 24 primary care studies the pooled effect-size was 0.33 (95% CI: 0.16 to 0.49; Badamgarav et al., 2003). Especially for the heterogeneous primary care population, there is a need to identify subgroups of patients who do, or do not, benefit from specific forms of treatment.

6.4.2 Methodological considerations

By using a screening procedure we avoided the biased selection that might have occurred when participants were recruited by GPs. Additional positive aspects of this study are that we used concealed allocation and had independent evaluators. As we wanted to perform a pragmatic trial, we limited the exclusion criteria as much as possible. Because it has been demonstrated that also mild forms of depression are consequential for well-being and disability (Beekman et al., 1997), we included these patients in our trial, to find out whether they would benefit from IPT. As was discussed by Posternak (2002), data on the efficacy of antidepressant treatments for mild depression are conflicting. In recent years, several primary care studies have found that in patients with mild depression hardly any treatment effect could be demonstrated, because the percentages of spontaneous remissions came close to that of an optimal treatment effect (Bruce et al, 2004; Barrett et al., 2001; Williams et al., 2000). Our data confirmed these findings. Because the percentage of patients with mild depression was high, the power to demonstrate a significant treatment effect in patients with moderate to severe depression was negatively influenced.

We focused on IPT as a mono therapy. Depression treatment as a whole will most probably be more effective when patients can choose or switch between antidepressants and IPT, or can get combination therapies. This approach takes implicitly account of the heterogeneity of the population. Interestingly, it was recently demonstrated that a switch from an antidepressant medication to psychotherapy or vice versa was useful for non responders to the initial treatment (Schatzberg et al., 2005).

Consonant with real-life circumstances, no experienced IPT therapists were available in primary care. Therefore, we had to train therapists in the initial

phase of the study. We did not use specific selection criteria other than being motivated to participate. This approach may have affected treatment integrity, and have decreased effectiveness. Furthermore, the relatively low "dose" of IPT (10 instead of 14 sessions) was probably not enough for the patients with moderate to severe depression as Shapiro et al. (1994) have found that patients presenting with relatively severe depression improved substantially more after 16 than after 8 sessions of IPT.

In research comparing psychotherapy with usual care or medication, it is not possible to blind patients and therapists to the intervention. Patients in the IPT group may therefore have been more positive about treatment outcome. However, patients in the usual care group may have informed their GPs about their participation in the study and have asked for treatment of the depression. Therefore, the effect of a lack of blinding may be both an over- and an underestimation of the effect of IPT.

The care as usual condition in our study was probably of higher quality than the 'real' usual care in the Netherlands. We randomised at the patient level, not at the practice level, to reduce possible bias by different patient samples per practice. Consequently, GPs may have treated their study patients more actively than they were used to, because the project was being carried out in their practice. Additionally, the participating GPs may represent a group with above average affinity with the care for depressed elderly patients. These factors may have resulted in a less pronounced IPT/CAU difference in our study than is to be expected in general.

6.4.3 Conclusions

This is the first study supporting that IPT is effective in real-life general practice for elderly patients with moderate to severe major depressive disorder. This finding is especially noteworthy, as the therapy dose was relatively low and the therapists were not very experienced in delivering IPT.

The fact that in the present and in other studies only one third of the patients reached full remission needs further study. Diagnostic or intervention strategies should probably be adapted to elderly depressed patients. It can be concluded that there are grounds to support the delivery of IPT to moderately or severely depressed elderly patients in real-life general practice, but evidence is still limited. It should be stated that there is also hardly any evidence for the effectiveness of antidepressant drug treatment in comparison to CAU or to some form of short term psychotherapy in this group of patients (Freudenstein et al., 2001). What we do know is that more extensive depression care enhancing

projects, including antidepressant drugs and/or psychotherapy, were effective (Bruce et al., 2004; Unützer et al., 2002). Given the large and growing number of older primary care patients that may benefit from effective treatment, it is very important to further uncover which types of interventions may be of benefit to which types of older patients. This requires studies adopting various treatment strategies and studies large enough to discern patient and doctor related factors that may modify the effects of treatment. In the mean time, especially among (older) patients with more severe depression, offering both IPT and medication may be the most appropriate strategy.

CHAPTER 7

Predictors of outcome in participants of two intervention studies for elderly depressed patients in primary care.

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Abstract

Objective To identify patient characteristics that predict (treatment) outcome in elderly patients with major depressive disorder in primary care.

Methods Predictors of outcome were explored in two separate, identically designed randomised controlled trials: the IPT study that compared the effectiveness of Interpersonal Psychotherapy (IPT) with usual GP care (CAU), and the West Friesland study that compared guideline driven drug treatment by the GP with CAU. The primary depression outcomes were diagnosis of depression, measured with the PRIMary care Evaluation of Mental Disorders (PRIME-MD) and remission, defined as a score of < 10 on the Montgomery Åsberg Depression Rating Scale (MADRS). The predictive value of 13 candidate predictors was studied using backward logistic regression.

Results Overall, the predictors of poor outcome were a higher age, a lower educational level, recent life events, a lower level of social functioning, higher initial depression severity, a lower level of physical functioning, and panic symptoms. IPT was more effective in patients with recent life events than in patients without such events. IPT was also more effective in women than in men. There were no other interactions with treatment.

Conclusions Patients who have characteristics that predict poor outcome should be treated and monitored more intensively and should probably be referred earlier to secondary care. IPT may be especially indicated for depressed patients with recent life events, as life events predicted a favourable outcome in patients treated with IPT, while they predicted poor outcome in all other groups.

7.1 Introduction

In recent years much attention has been paid to the detection and treatment of depressed elderly patients in primary care. It has been found that antidepressant drug treatment and psychotherapy as monotherapies and as part of more comprehensive depression care enhancing programmes, are more effective than care as usual (Bruce et al., 2004; Freudenstein et al., 2001; Unützer et al., 2002; Van Schaik et al., 2006). However, treatment effects varied across studies, and overall effects were modest.

Different factors determine this variance in treatment outcome. To further improve depression care it is important to explicitly address these factors. First, there are differences in the organisation of primary health care that may influence treatment outcome. For example, European primary care settings are different from the managed care settings in the United States in terms of continuity of care and open access. Therefore, there may be considerable differences in the (usual) care conditions among studies. Second, studies differ in the extent to which they succeed in delivering optimal care. Physician factors and therapist factors are important in this regard. Third, and this will be the topic of the current paper, patient characteristics determine outcome in general, and in relation to specific treatment options. When these patient characteristics are known, treatment strategies can be applied more selectively, resulting in a more effective and more efficient depression care overall.

Several researchers have explored predictors of outcome for depression in younger adults in primary care (e.g. Brown et al., 2000; Corey-Lisle et al., 2004; Limosin et al., 2004; Mynors-Wallis & Gath, 1997a; Sherbourne et al., 2004; Walker et al., 2000). The predictors that were identified in these studies are summarized in Table 7.1. None of these studies have focussed on determinants of (treatment) outcome in elderly depressed patients in primary care, while it is likely that there are relevant differences between elderly patients and younger adults. For example, older attendees of general practice often have physical health problems, and work-issues are not relevant for most patients of this age group. Therefore, we studied determinants of outcome in two highly comparable intervention studies on elderly patients with major depression in general practice. In the first study, Interpersonal Psychotherapy (IPT) was compared with usual GP care (IPT study), and in the second study, guideline driven antidepressant drug treatment by the GP was compared with usual GP care (The West Friesland study (WF study)). The treatment effects of these studies were modest, but there was much variation in outcome, which supports the importance of revealing predictors of outcome.

Our research questions were:

1) What are the most important patient characteristics predicting outcome among elderly patients with major depression in general practice?
2) Are these characteristics similar for antidepressant drug treatment and for psychotherapy (IPT) i.e. do these predictors interact with the treatment conditions?

Table 7.1 Patient factors predicting poor outcome in depressed younger adults in primary care

Sociodemographic	Older age Unemployment Race (African American in US)
Psychosocial vulnerabilities	Lack of social support Low social functioning Current stress Personality pathology, neuroticism External health locus of control
Depression	High initial depression severity Suicidal ideation Low energy level Long duration of illness Recurrent depression
Physical functioning	Medical co morbidity Low physical functioning
Psychiatric co morbidity	Panic disorder
Other	Non adherence to medication

7.2 Methods

7.2.1 Design and setting

This study explores the predictors of outcome in two randomised controlled trials that were designed in order to allow for the analyses that are the subject of this paper. The methods of both studies have been reported elsewhere (Bijl et al., 2003; van Schaik et al., 2006), but will be briefly summarized here. The IPT study and the WF study were performed in separate groups of general practices, all in and around the Amsterdam area. The design of the studies was identical except for the randomisation procedures. In the WF study, randomisa-

tion was performed at the practice level as the GPs delivered the intervention, and contamination between treatment conditions was therefore probable. In the IPT study randomisation was carried out at the patient level, per practice, as a mental health worker gave the IPT, and contamination of the care as usual (CAU) was not very likely.

Samples. In both studies patients were recruited in exactly the same way by means of a two-stage screening procedure in which all individuals of 55 years or older who had recently visited the GP, were sent a depression screening questionnaire: the 15-item Geriatric Depression Scale (GDS-15, range 0-15, higher scores indicate more depressive symptoms; Sheikh & Yesavage, 1986). Respondents, who scored 5 or more on the GDS-15, were contacted by telephone by one of the research assistants and were invited for further diagnostic examination. If they consented, a diagnosis of depressive disorder was assessed by the research assistant who administered the mood module of the PRIMary care Evaluation of Mental Disorders (PRIME-MD; Spitzer et al., 1994). Excluded were respondents who had: (i) treatment for depression at the time of screening, (ii) insufficient understanding of the Dutch language or (iii) severe cognitive impairment (Mini-Mental State Examination score of <18). All participants gave written informed consent after the study procedures were fully explained.

Interventions. In the IPT Study, mental health workers delivered 10 sessions of IPT in the general practices within five months. In the WF study GPs were trained in using the diagnostic and treatment guidelines for depression of the Dutch College of General Practitioners (NHG). Treatment consisted of psycho-education about depression and drug treatment (paroxetine 20 mg daily) accompanied by clinical management (monitoring of symptoms and supportive counselling by the GP).

7.2.2 Outcome

We explored the predictors of two outcomes: a) diagnosis of major depression (yes/no) and b) 'remission' (yes/no) at six months. Major depression was assessed by means of the PRIME-MD mood module. Remission was defined as having a score of < 10 on the MontgomeryÅsberg Depression Rating Scale. (MADRS, range 0-60, higher scores indicate higher severity of depression; Montgomery & Asberg 1979; Hawley et al., 2002). Trained, independent interviewers carried out the assessments.

Predictors. We measured 13 candidate predictors of outcome. Nine of these determinants were already identified as predictors of outcome in younger depressed adults in primary care: age, current stress (life-events schedule,

developed for the Longitudinal Aging Study Amsterdam, Beekman et al., 1995), social functioning (social functioning subscale of the Medical Outcome Study 36-item Short Form Health Survey (SF-36), range 0-100, higher score indicates better functioning; Ware, 1992) , neuroticism (NEO-FFI, range 0-60; higher score indicates more neuroticism; Costa & McCrae, 1992), locus of control (range 0-20, higher score indicates more internal locus of control; Pearlin & Schooler, 1978), baseline depression severity (MADRS), physical functioning (SF-36, physical component summary score), anxiety (PRIME-MD anxiety module), and treatment. We added two variables because of their possible predictive value in elderly patients: age of onset of the first depression and functional dependency, ADL (range 0-12; higher score means more functional dependency; Brorsson and Asberg, 1984). Furthermore, we added gender and level of education as candidate predictors because therapists of the IPT research project suggested at the end of the project that IPT was less effective in elderly men, and in patients with a lower educational level.

7.2.3 Analysis

For both the IPT and the WF study, a comparison of the baseline sociodemographic and clinical characteristics of the intervention and control group was already made; it was concluded that randomisation within these studies had succeeded. (Bijl et al., 2006; van Schaik et al., 2006). In order to compare the determinants of outcome in both studies, we explored possible differences between the patient samples by combining the data of both studies resulting in four groups: the IPT intervention group (IPT_{int}), the IPT usual care group (IPT_{CAU}), the WF_{int} group, and the WF_{CAU} group. We carried out ANOVA for the continuous variables and X^2 for categorical variables.

With regard to missing data: we did not impute missing values, but performed the analyses on available data. To explore potential differential attrition we compared the demographic and clinical characteristics of the participating patients in the intervention and control groups at six months. We knew that there were no differences at baseline, and if there were still no differences at six months, it could be concluded that the attrition had not been selective, otherwise we would have to correct for these differences.

We analysed the determinants of outcome for each study separately. We performed backward logistic regression to identify the most important predictors of not having a diagnosis of depression anymore post treatment (at six months). In contrast to etiological research, it is common in prediction research to use a more liberal p-value than 0.05 for keeping variables in the model (e.g.Harrell

Table 7.2 Candidate predictors in the IPT and WF study

	IPT_{int} (N=69)	IPT_{CAU} (N=74)	WF_{int} (N=70)	WF_{CAU} (N=75)	Statistic $X^2_{[df]}$ or $F_{[df]}$	P value
Sociodemographic						
Age, mean (SD)	68.4 (8.1)	67.5 (9.2)	67.0 (9.0)	65.6 (8.2)	$1.3_{[3]}$	0.28
Women	48 (70)	51 (69)	42 (60)	41 (55)	$4.9_{[3]}$	0.18
Level of Educational Low Intermediate High	 23 (33) 27 (39) 19 (28)	 32 (43) 25 (34) 17 (23)	 49 (70) 17 (24) 4 (6)	 45(60) 23(31) 7(9)	$28.0_{[6]}$	< 0.00
Psychosocial vulnerabilities						
Patients with recent life event(s)	42 (61)	41 (56)	37 (54)	44 (59)	$0.68_{[3]}$	0.88
SF-36, Social functioning subscale, mean (SD)	58.0 (27.8)	60.5 (27.1)	58.4 (23.9)	50.2 (26.6)	$2.18_{[3]}$	0.09
Depression						
MADRS, mean (SD)	19.4 (7.9)	19.3 (8.6)	19.9 (8.2)	19.2 (7.7)	$0.12_{[3]}$	0.95
Patients with onset before age 50	36 (52)	46 (63)	36 (54)	49 (68)	$5.0_{[3]}$	0.17
Physical functioning						
ADL, mean (SD)	0.8 (0.9)	1.0 (1.7)	1.0 (1.5)	0.8 (1.1)	$0.6_{[3]}$	0.60
SF-36, Physical component score, mean (SD)	39.4 (11.2)	41.2 (11.0)	40.6(12.8)	40.1 (12.9)	$0.29_{[3]}$	0.84
Psychiatric comorbidity						
Patients with panic symptoms	17 (25)	19 (26)	26 (37)	19 (25)	$3.74_{[3]}$	0.29

Note: Data are presented as N (%), unless otherwise specified. SD: standard deviation.

et al., 1996). We used a p-value of 0.10. Finally, we entered the interaction terms of every candidate predictor with treatment in the regression equation and performed backward regression again. The same procedure was carried out with regard to the other outcome measure, remission after six months. For these analyses, SPSS for Windows, version 11.0 was used. In these analyses, the extent to which a variable predicts outcome is expressed in (Exp(b))= e^b. As this value is equal to the odds ratio, we present the odds ratios.

7.3 Results

Table 7.2 compares the demographic and clinical characteristics of the patients from the IPT and WF studies. Patients in the WF study had on average a lower level of education; none of the other variables differed significantly between the four groups. In the IPT study, 11 patients (16%) from the intervention group and 12 patients (16%) from the control group dropped out before six months. In the WF study, these numbers were 10 (14%) and 9 (12%) respectively. As there were no differences between the baseline characteristics of the participating patients in the intervention and control groups of both studies at 6 months, we concluded that there was no selective dropout of participants.

In the IPT study, the predictors of a favourable outcome (no diagnosis of major depression anymore) at six months were: a) a higher level of education, b) better social functioning at baseline, c) absence of co morbid panic symptoms, and d) receiving IPT treatment instead of CAU. Furthermore, two patient characteristics interacted with treatment: i) IPT was more effective in women than in men, and i) IPT was more effective for patients who had experienced a recent life event than for patients without such events. In Table 7.3, the last step of the backward regression model is described; the b represents the regression coefficient of the variable in the logistic regression equation. The significance of this value is tested by the Wald test, and its p-value. The extent to which a variable predicts treatment outcome is expressed in the odds ratio. For categorical data such as a higher educational level, an OR of 3.55 means that patients with the highest level of education have 3.55 times more chance to have no diagnosis of depression anymore at six months, than patients with the lower level of education. For continuous variables the OR is based on one unit of the measure that was used. To interpret the relevance of this result, the OR for a clinical relevant difference should be calculated. For example, the OR based on one unit of the SF-36 social functioning score was 1.03 (Table 7.3). A clinically relevant difference on this measure is 26 units (one standard deviation, see Table 7.2). The OR for 26 units is 26 x 0.03= 0.78. Exp(0.78)= 2.18. This means that patients, who

score one standard deviation higher on the social functioning scale at baseline, have 2.18 times more chance to have no diagnosis of depression anymore at six months than patients with the lower score.

Table 7. 3 Predictors of having no diagnosis of depression anymore in the IPT study at 6 months.

Variable	b	Wald$_{[df]}$	p- value	OR	95,0% CI for OR	
					Lower	Upper
Sociodemographic						
Gender	0.07	<0.01$_{[1]}$	0.93	1.07	0.25	4.59
Level of education						
Low		4.30$_{[2]}$	0.12			
Intermediate	0.70	1.86$_{[1]}$	0.17	2.02	0.74	5.51
High	1.27	3.94$_{[1]}$	0.05	3.55	1.02	12.38
Psychosocial vulnerabilities						
SF-36, Social functioning	0.03	9.15$_{[1]}$	<0.01	1.03	1.01	1.05
Psychiatric comorbidity						
Panic symptoms	-0.87	2.87$_{[1]}$	0.09	0.42	0.15	1.15
Other						
Treatment	1.03	2.54$_{[1]}$	0.11	2.80	0.79	9.93
Treatment x gender interaction	-2.07	3.97$_{[1]}$	0.05	0.13	0.02	0.97
Treatment x life events interaction	1.38	4.51$_{[1]}$	0.03	3.97	1.11	14.17

Note: b: regression coefficient ; OR: odds ratio

Three variables predicted remission in the IPT study: a) younger age, b) less initial depression severity, and c) better physical functioning (Table 7.3a). Treatment condition was not significantly associated with remission in the IPT study, because in both conditions, only one third of the patients achieved remission.

Table 7.3a. Predictors of remission in the IPT study at 6 months.

Variable	b	Wald $_{[df]}$	p- value	OR	95,0% CI for OR	
					Lower	Upper
Sociodemographic						
Age	-0.08	$7.08_{[1]}$	<0.01	0.92	0.87	0.98
Depression						
MADRS	-0.08	$6.38_{[1]}$	0.01	0.93	0.87	0.98
Physical functioning						
Sf-36, Physical component	0.04	$3.65_{[1]}$	0.06	1.04	1.00	1.08

Note: b: regression coefficient ; OR: odds ratio

In the WF study, the predictors of having no diagnosis of major depression anymore at six months were: a) younger age, b) less initial depression severity, and c) absence of co morbid panic symptoms (Table 7.4). Treatment condition was not a significant predictor in this model, as in both treatment conditions patients improved equally well (62% had no diagnosis of depression anymore at six months). In the WF study no data were available on neuroticism and locus of control; therefore, the predictive value of these determinants could not be explored.

Predictors of remission in the WF study were: a) lower level of social functioning, b) no recent life events, c) less initial depression severity, d) higher level of physical functioning, and e) being treated in the WF_{int} condition (Table 7.4a). There were no significant interactions of the predictors of remission with treatment.

Table 7. 4 Predictors of having no diagnosis of depression anymore in the WF study at 6 months.

Variable	b	Wald $_{[df]}$	p- value	OR	95,0% CI for OR	
					Lower	Upper
Sociodemographic						
Age	-0.09	$11.72_{[1]}$	<0.01	0.91	0.86	0.96
Depression						
MADRS	-0.06	$5.16_{[1]}$	0.02	0.94	0.89	0.99
Psychiatric comorbidity						
Panic symptoms	-0.81	$3.46_{[1]}$	0.06	0.44	0.19	1.04

Note: b: regression coefficient ; OR: odds ratio

Table 7.4a. Predictors of remission in the WF study at 6 months.

Variable	b	Wald $_{[df]}$	p- value	OR	95,0% CI for OR	
					Lower	Upper
Psychosocial vulnerabilities						
Recent life event(s)	-0.73	$3.08_{[1]}$	0.08	0.48	0.21	1.09
Social functioning	-0.02	$3.12_{[1]}$	0.08	0.98	0.96	1.00
Depression						
MADRS	-0.11	$10.75_{[1]}$	<0.01	0.89	0.83	0.95
Physical functioning						
Sf-36, physical component	0.03	$3.28_{[1]}$	0.07	1.03	1.00	1.07
Other						
Treatment	1.35	$9.28_{[1]}$	< 0.01	3.84	1.62	9.13

Note: b: regression coefficient ; OR: odds ratio

7.4 Discussion

7.4.1. Summary

In this study we explored the predictive value of 13 candidate predictors in two intervention studies for elderly patients with major depression in primary care in the Netherlands. Our aim was 1) to identify determinants of outcome, and compare them with the determinants found in younger depressed adults, and 2) to explore possible differences in determinants of outcome for antidepressant drug treatment and for IPT. 1) Nine of the 13 candidate predictors had a predictive value in our studies on elderly patients, although the relative importance of these variables differed depending on outcome measure and study. Of the variables that were identified as predictors in younger adults, age, recent life events, social functioning, initial depression severity, physical functioning, panic symptoms and treatment, predicted outcome in both of our studies; neuroticism and locus of control did not. Of the four candidate predictors we added, age of onset of the first depression and functional dependency had no predictive value. In the IPT study, level of education and gender did affect outcome. 2) In the IPT study, there was a significant interaction between the IPT intervention and one or more recent life event(s), and between the IPT intervention and gender. In the WF study, no interaction terms of the candidate predictors with treatment were significant.

7.4.2 Methodological considerations

We had the opportunity to analyse and compare possible predictors of outcome in two randomised controlled trials that have recently been carried out at our research institute and that were similar in their design. Although the baseline characteristics did not differ between the studies, except for the level of education, other factors may have contributed to differences between the studies in the predictive power of the determinants. However, the fact that age, recent life events, initial depression severity, physical functioning, panic symptoms and treatment were predictive in both studies, and were identified by others (Table 7.1) supports the predictive value of these characteristics. A high level of education predicted a favourable outcome in the IPT study, not only in the intervention group, as we hypothesized, but also in the care as usual group. Probably, patients who are highly educated are more effective in their asking for help and in making use of the treatment offered. In the WF study only few patients were highly educated, consequently the predictive role of education could not be sufficiently explored in this study. The IPT intervention proved to be more effective in women than in men. As far as we know female gender as a predictor

of a positive treatment outcome in IPT has not been identified before. However, gender as a predictor of outcome in psychotherapy and in depression treatment was detected by others (Goode, 2004; Pyne et al., 2003). Recent life events predicted a favourable outcome in patients receiving the IPT intervention, while in the WF study and in other studies life events/current stress predicted poor outcome. In IPT recent life events and their influence on interpersonal functioning are explicitly the focus of the therapy. It is assumed that disturbed interpersonal functioning strongly interacts with the depression, and that depressive symptoms decrease when the interpersonal functioning has improved. Our data seem to support the importance of focussing on recent life events in IPT. ADL turned out not to be a predictor of poor outcome in our studies. This may be explained by the fact that there was hardly any variance in ADL scores in our samples, as the vast majority of our participants was functionally independent.

7.4.3. Conclusions

We identified several patient characteristics with a predictive value for the outcome of major depression in elderly primary care patients. Overall, a higher age, a lower educational level, recent life events, a lower level of social functioning, higher initial depression severity, a lower level of physical functioning, and panic symptoms predicted poor outcome. Patients who have these characteristics should be treated and monitored more actively, for example by offering a combination treatment or by earlier referral to secondary care for further diagnostic examination and other forms of treatment. The finding that recent life events predicted a favourable outcome in the IPT intervention group, while in the IPT control group and in the WF study they predicted poor outcome, may have implications for clinical practice. IPT may be especially indicated for patients who experienced recent life events. This interesting issue needs further study. The same holds for the finding that IPT was more effective for elderly women than for elderly men.

This study adds to the knowledge of predictors of outcome in depressed elderly patients in primary care. It is important to continue research on predictors of (treatment) outcome in this patient group. In primary care, the patients who present with depressive symptoms are very heterogeneous and if we know which patients benefit from what depression treatment, a specific algorithm may be developed to help the GP and the individual patient to decide which treatment is the most suitable.

CHAPTER 8

Summary and General Discussion

8.1 Summary

8.1.1 Background

The aim of this thesis was to study the feasibility and effectiveness of Interpersonal Psychotherapy (IPT) for late life depression in general practice. Previous research had shown that:

- Depressive disorder is common among elderly patients in the community and in primary care.
- The prognosis of depression in elderly patients is poor.
- Depression leads to serious disability and reduced general functioning
- Depression is associated with increased use of medical services.
- Antidepressant drug treatment and some forms of psychotherapy have been proven to be effective in older depressed patients in secondary care; little is known about their effectiveness for elderly depressed patients in normal life general practice.
- In primary care, a minority of older depressed patients is given a specific depression treatment.

We hypothesized that the prognosis of major depressive disorder in older primary care patients could be improved by treating them with one of the evidence based therapies. We chose to deliver a psychological intervention (IPT) because older patients are more sensitive to side effects of antidepressant drugs and often use other medication, which increases the risk of unwanted drug interactions. Because older patients are often reluctant to be referred, the IPT was delivered within general practice, thereby making it more easily accessible.

To assess the feasibility and effectiveness of the IPT intervention we conducted a randomised clinical trial comparing IPT with care as usual by the GP. Before the start of this trial we had to train the therapists in IPT. We developed training materials and wrote a Dutch manual for IPT in older patients. We carried out three reviews of the literature. Finally, we performed a study on predictors of treatment outcome in the IPT study and in a parallel antidepressant drug intervention study.

8.1.2. Effectiveness of psychotherapy for depression in general practice. A review of the literature (Chapter 2)

As we wanted to know what treatment effect we could expect in our randomised controlled trial, we performed a systematic review of the literature on the effectiveness of psychotherapy for depressive disorder in primary care. Because there were no studies focussing on elderly patients with major depres-

sive disorder, we had to rely on data in younger adults (nine studies) and in elderly patients with minor depression or dysthymia (one study). The pooled effect size of psychotherapy compared with usual GP care was 0.3 (95% CI: 0.1-0.5), representing a small treatment effect. There was no difference in treatment effect of antidepressant drug treatment and psychotherapy, effect size –0.08 (95% CI: -0.21-0.05). In elderly patients with minor depression or dysthymia short term psychotherapy (problem solving therapy) was not superior to pill placebo. We concluded from this review that the treatment effect we could expect in our study comparing psychotherapy (IPT) with usual GP care for major depression in older patients, was most probably small (effect size < 0.5). Furthermore, this review made us aware of a possible interaction between initial depression severity and treatment effect: we found some indications that patients with initial moderate to severe depression who received psychotherapy, improved more compared with usual GP care or placebo, than patients having a minor or mild depression at baseline (Friedli et al., 1997; Barrett et al., 2001; Williams et al., 2000; Elkin et al., 1995).

8.1.3 Cost-effectiveness of psychological treatments for depression in primary care. A systematic review (Chapter 3)

When studying the implementation potential of IPT in general practice, the cost-effectiveness of this and other comparable interventions is important. A systematic search of the literature revealed five cost-effectiveness analyses that were performed alongside randomised controlled trials described in Chapter 2, and one additional study.

Four economic studies compared psychotherapy and/or counselling with CAU, three studies compared psychotherapy with antidepressant drug treatment. At the one-year follow-up, none of the studies could demonstrate that the psychological intervention resulted in a reduced use of other health care services, but studies lacked power to detect these possible cost differences. In one study, IPT was significantly more effective than CAU, but at higher costs.

We concluded from this review that there is not enough evidence for the cost-effectiveness of psychological interventions in primary care, and that no firm conclusions can be drawn. Cost-effectiveness may be increased by improving the psychotherapy interventions, or by delivering them more selectively. This might lead to a cost offset in the use of other health services, but probably not. However, if the costs are calculated optimally, decision makers in health care can decide at what costs they are willing to improve depression care i.e. whether the estimates of the cost for psychotherapy per quality of life year

gained are comparable to those found for other treatments provided in routine practice.

8.1.4 Patients' preferences in the treatment of depression in general practice. A review of the literature (Chapter 4).
Because we realised that patients' preference should be taken into account when introducing a treatment option that is not usually available in general practice, we performed a systematic review on patients' preferences in the treatment of depressive disorder in general practice. We selected studies that presented data about attitudes or preferences towards psychotherapy and antidepressant medication, because these are the main treatment options recommended in depression treatment guidelines. In all studies, psychotherapy or counselling were more often preferred than antidepressants. Among depressed populations 51–69 % of patients preferred psychotherapy or counselling, compared with 20-38% who preferred antidepressants. Among non-depressed respondents 32-98% had a positive attitude towards psychotherapy or counselling, compared with 15- 35% towards antidepressant drug treatment. Few studies paid attention to the underlying assumptions of these preferences. It was found that preferences are sometimes based on false assumptions. In the clinical trials in which sufficient information was provided, the majority of patients still preferred psychotherapy or counselling. We concluded from this review, that there is no doubt that making psychotherapy more easily accessible as a treatment option for depression in general practice, is in concordance with the preferences of at least 50% of the patients.

8.1.5 Feasibility and barriers to providing Interpersonal Psychotherapy for late life depression in general practice (Chapter 5).
Feasibilty aspects and barriers to organising IPT in general practice were recorded during our randomised controlled trial comparing IPT with usual GP care. Motivation and evaluation of all participants (patients, general practitioners, specialist mental health centres and therapists) were assessed. Of the 205 eligible patients with current major depression, 143 (70%) gave informed consent and therefore had a positive or neutral attitude towards the psychotherapy intervention. Of the patients who started the psychotherapy at least 77% were compliant. We approached 18 general (mostly group) practices, and 12 participated. Lack of office space for the additional therapists was mentioned as the main barrier to participation. The two psychologists' private practices that were interested in IPT, could not join the project, because of financial and

organisational reasons. All four specialist mental health centres that were approached were motivated, as long as the extra workload of the therapists would be limited. The geriatric teams of these organisations received training in IPT, and it turned out that the majority of therapists were interested in joining the research project.

After treatment had finished the intervention was evaluated by all participants. Patients evaluated the IPT intervention positively. GPs (N=22) positively evaluated the time-limited, practical and structured nature of IPT. All but one GP stated that they were motivated to implement this intervention. The participating therapists (N=15) also positively evaluated the structure and strategies provided by the IPT protocol. They liked to work within the general practice, although they occasionally needed extra time and flexibility to find an office space, one found this a very unpleasant complication.

We concluded that it is feasible to make IPT available in general practice for elderly patients with major depression as long as the practices have space for the therapists and financial barriers can be overcome.

8.1.6 Interpersonal Psychotherapy (IPT) for elderly depressed patients in primary care. (Chapter 6).

A total of 143 patients were randomly assigned to IPT (N=69) or usual GP care (N=74). Patients in the IPT group were offered 10 sessions of IPT. Assessments were carried out at baseline and after two and six months. Primary outcome measures were: remission of depression (defined as a score of less than 10 on the Montgomery Åsberg Depression Rating Scale , MADRS), Diagnosis of depression (DSM-IV criteria assessed by the mood module of the PRIMary care Evaluation of Mental Disorders, PRIME-MD), and Depression severity (continuous MADRS and GDS-15 scores). The secondary outcome measure was general functioning measured with the Medical Outcome Study 36-item Short Form Health Survey (SF-36).

We found that IPT was more effective than usual GP care in reducing the number of patients with a diagnosis of major depressive disorder post treatment. When using a conservative estimate, 17% more patients in the IPT group had no diagnosis anymore post treatment. Remission rates were relatively low (32-33%) and did not differ between the groups. Among treatment completers, IPT was superior in improving social and overall mental functioning. A post hoc analysis revealed that severity of the index depression had a differential effect on treatment outcome: the superior effect of IPT over usual GP care was more pronounced in those with moderate to severe depression (MADRS>20) at

baseline.Thus, our findings were in line with the conclusion of the systematic review, described in Chapter 2, that overall treatment effects are relatively small in primary care studies concerning interventions for depressive disorder. In addition, remission percentages are lower in elderly patients than in younger adults.

8.1.7 Predictors of outcome in participants of two intervention studies for elderly depressed patients in primary care (Chapter 7).

Predictors of outcome were explored in the IPT study described in this thesis, and the parallel West Friesland study that compared guideline driven drug treatment by the GP with CAU. These studies were identically designed. The primary depression outcomes were diagnosis of depression, measured with the PRIMary care Evaluation of Mental Disorders (PRIME-MD) and remission, defined as a score of < 10 on the Montgomery Å sberg Depression Rating Scale (MADRS). The predictive value of 13 candidate predictors was studied using backward logistic regression. We found that a higher age, a lower educational level, recent life events, a lower level of social functioning, higher initial depression severity, a lower level of physical functioning, and panic symptoms predicted poor outcome. IPT was more effective in patients with recent life events than in patients without such events. IPT was also more effective in women than in men. There were no other interactions with treatment.

In conclusion, we found some predictors of poor outcome in elderly primary care patients, which were identified before in younger patients. Patients with these characteristics should be treated and monitored more intensively and should probably be referred earlier to secondary care. Further study should be made of the interesting finding that IPT was more effective in elderly women than in elderly men, and in patients who experienced a recent life event.

8.2 Discussion

As was pointed out in Chapter 1, we focussed on two barriers to optimal depression treatment: the insufficient detection and acknowledgment of major depression, and the absence of evidence based psychotherapy in most general practices. We used a screening procedure to improve detection and introduced IPT in general practice. Now, we can discuss our findings.

8.2.1 Screening for depression

Screening for depression was feasible in our research project as long as the GPs did not have to carry out the screening themselves. GPs were not moti-

vated to perform the screening themselves, because of time restraints. By using the screening procedure, described in Chapter 6, we were able to include the planned number of patients within the reasonable time period of one and a half year, and we avoided the biased selection that might have occurred when participants were recruited by the GPs themselves. However, the screening procedure, in which we used a "symptom count" approach by means of the PRIME-MD mood module, had an important limitation: probably too many patients were identified as having a depressive disorder. Many of them had only mild symptoms of depression, and we found that for these patients, specific depression treatment did not add much to usual care. In the combined populations of our study and the West Friesland study, the prevalence of major depression according to the PRIME-MD was 13.7% (95% CI 7.7% - 19.8%; Licht-Strunk et al., 2005). In our sample, 57% of the patients had only mild depressive symptoms (baseline MADRS score < 21). Of these identified patients, 72% were not being treated. Thus, the prevalence of depression in our sample was high, but in line with that found by others (Lyness et al., 1999; Schulberg et al., 1998). Our finding that only a minority of the identified patients was being treated for depression was also in concordance with the literature. We assumed that treating all of these patients would improve their prognosis, especially because depression in elderly patients often has a chronic recurrent course, and the burden is high (Beekman et al., 1997). However, it can be argued that the concept of depression is extended too much by using only DSM-IV criteria. Mild symptoms of depression are harder to classify meaningfully. The symptoms can represent early stages of more severe depression, as well as reactions to upsetting life events or the response to adverse social circumstances or physical disease (P. Eikelenboom, personal communication; Freudenstein et al., 2001). Probably, GPs are right in their restraint to treat all of these patients for depression, as they already know, based on clinical experience, that for many of these patients specific depression treatment has no additive value.

In conclusion, our strategy to use the computerized databases of the general practices to select patients for screening was feasible and useful, but for future intervention studies in primary care an additional depression severity measure is necessary to select more severely depressed patients for whom specific depression treatment is indicated.

8.2.2. Transmural IPT for depression in elderly primary care patients

At the start of our project, we stated (see Chapter 1) that "If it could be demonstrated that it is feasible and effective to deliver evidence based psycho-

therapy transmurally, this would prove that 'expertise transfer' and collaboration between primary and secondary care settings is an effective approach in daily practice, and that organisational changes, necessary to implement this intervention, should be supported". We can conclude that we succeeded in the 'expertise transfer' from secondary to primary care: we delivered IPT, a psychotherapy that was developed for secondary care patients with major depression, to elderly patients in primary care, and afterwards patients, therapists, and general practitioners evaluated the intervention positively. However, there were some restrictions to the use of IPT. One aspect of the IPT protocol did not fit many of the patients in our study, illustrating that 'expertise transfer' as such may not be adequate for all patients: According to the standard IPT protocol the depression should be discussed explicitly as an illness that can be treated. In an early stage of the project, it became clear that this approach was not workable for the patients who had more diffuse, mild depressive symptoms. The therapists were convinced that speaking about a depressive illness was inappropriate for these patients, and the patients did not recognise themselves in a depressive illness either. Therefore, the therapists linked the interpersonal problems to the complaints of the patients instead of to a depressive disorder. Again, this illustrates that the group of patients with mild depression should be approached differently.

Of course, the implementation of an intervention can only be supported if it is (cost) effective. In our study, treatment effects were modest. This result was in line with the results of our review on the effectiveness of psychotherapy as a monotherapy in primary care (Chapter 2). We mentioned that the effectiveness might be increased, not only by delivering the evidence based psychotherapies optimally and more selectively, but also by delivering them as part of more comprehensive collaborative care projects, in which the GP is supported by a depression manager (nurse or psychologist) in delivering guideline driven care, and in which treatments are tailored to individual patient needs. The results of these projects in the elderly were promising (Unützer et al., 2002; Bruce et al., 2004). Recently, an economic evaluation of the IMPACT study, in which IPT was optional, was published (Katon et al., 2005). The authors concluded that the IMPACT intervention was a high-value investment for older adults; and that it was associated with high clinical benefits at a low increment in health care costs.

In the Netherlands, we do not yet have 'depression managers' in primary care. However, while our research project was being carried out, organisational changes in primary care have been continued: developments are leading to an important role of nurses in supporting doctors in specific tasks. Many general

practices are already supported in mental health care by a psychiatric nurse, and we think that evidence based psychotherapies such as IPT or Problem Solving Therapy (PST) fit well in the 'tool kit' of these nurses.

8.2.3 Future research

In future research on the improvement of depression care for elderly primary care patients in the Netherlands, attention should be paid to the cost-effectiveness of a collaborative care model. In addition, to make depression treatment more effective, some aspects should have ongoing attention: e.g. the unravelling of the heterogeneous group of elderly primary care patients who all present with depressive symptomatology (for example by studying symptom profiles); further identification of determinants of outcome in general, and in relation to specific treatment options; the comparison of IPT with PST or other short term psychotherapies; and the possible development of other or modified treatment options. Hopefully, this will lead to further improvement of depression care for the rapidly growing group of elderly patients.

CHAPTER 9

Samenvatting (Summary in Dutch)

Hoofdstuk 1. Inleiding.

In dit proefschrift staat de vraag centraal of Interpersoonlijke Psychotherapie (IPT), een geprotocolleerde vorm van psychotherapie, een haalbare en effectieve aanvulling kan zijn op het behandelaanbod voor depressieve ouderen in de huisartsenpraktijk. Uit eerder onderzoek was bekend dat:

- Depressies vaak voorkomen bij ouderen die de huisarts consulteren, 10% van hen voldoet aan de criteria voor een depressieve stoornis.
- De prognose van depressie bij ouderen niet gunstig is, na een jaar heeft de meerderheid nog steeds klachten.
- Depressie de kwaliteit van leven aanzienlijk vermindert.
- Patienten die een depressie hebben, verhoogd gebruik maken van (para)medische voorzieningen.
- Depressies in de huisartsenpraktijk vaak niet als zodanig benoemd en behandeld worden.

Uit deze onderzoeksbevindingen kan geconcludeerd worden dat depressie onder ouderen een serieus gezondheidszorgprobleem is, zeker ook gezien het toenemende aantal ouderen in de bevolking. Daarom is het van groot belang hiervoor een optimale detectie- en behandelstrategie te ontwikkelen.

Als een depressie gediagnosticeerd is, volgt een stapsgewijze aanpak: de huisarts legt aan de patiënt uit dat de klachten binnen een depressieve stoornis passen en geeft voorlichting over de depressie. Eventuele lichamelijke ziektes die de depressie kunnen veroorzaken of onderhouden worden uitgesloten of behandeld. Ook gaat de huisarts na of de patiënt medicatie gebruikt die van invloed is op de depressie. Verder zijn leefstijladviezen van belang, zoals het aanmoedigen tot lichamelijke activiteiten, het houden van een structuur in de dag en het afzien van het gebruik van alcohol en andere middelen die het psychisch functioneren beïnvloeden. Als de depressie aanhoudt zal de huisarts veelal voorstellen antidepressieve medicatie te gaan gebruiken. Soms ook worden patiënten verwezen voor een gesprekstherapie naar maatschappelijk werk, vrijgevestigd psycholoog of een instelling voor geestelijke gezondheidszorg. De meeste depressieve patiënten blijven echter bij de huisarts in behandeling. De werkzaamheid van antidepressieve medicatie en sommige vormen van geprotocolleerde psychotherapie is voornamelijk aangetoond bij depressieve patiënten die in de psychiatrische praktijk gezien worden. Er is weinig bekend over de effectiviteit van deze therapiëen voor depressieve ouderen in de huisartsenpraktijk. Bovendien zijn de “evidence based” psychotherapievormen vaak niet beschikbaar in de eerste lijn.

Het doel van het onderzoeksproject was om een bijdrage te leveren aan het optimaliseren van de depressiezorg voor ouderen in de huisartsenpraktijk. Het idee daarbij was om expertise in specifieke behandeltechnieken vanuit de tweede lijn over te dragen naar de eerste lijn. We hebben ons gericht op twee aspecten:

- Het verhogen van de detectie van depressie door een screeningsprocedure toe te passen onder alle ouderen die zich meldden in de deelnemende huisartsenpraktijken.
- Het laagdrempelig beschikbaar maken van een evidence based vorm van psychotherapie, Interpersoonlijke Psychotherapie (het behandelprotocol staat beschreven in de Appendix van dit proefschrift). We kozen voor een psychologische interventie, omdat juist ouderen gevoelig zijn voor bijwerkingen van antidepressieve medicatie en omdat zij vaak ook nog andere medicatie gebruiken, waardoor er een risico is op interacties tussen de diverse middelen. Aangezien ouderen verwijzing naar een GGZ instelling vaak een te grote stap vinden, werd de psychotherapie aangeboden ìn de huisartsenpraktijk, uitgevoerd door een GGZ medewerker.

Om de haalbaarheid en effectiviteit van IPT te bestuderen hebben we een gerandomiseerd gecontroleerd onderzoek uitgevoerd, waarin we de effectiviteit van IPT vergeleken met die van de gebruikelijke zorg door de huisarts. Dit project werd gefinancierd door Zorg Onderzoek Nederland (ZONmw). Aan het begin van het project hebben we therapeuten en huisartsen geworven voor deelname. We hebben trainingsmateriaal ontwikkeld, waaronder een handleiding voor therapeuten in het Nederlands, en therapeuten getraind in IPT. Daarnaast hebben we drie literatuurstudies verricht om het onderzoeksproject in een breder perspectief te kunnen plaatsen. Verder hebben we geanalyseerd welke factoren een (on)gunstig beloop voorspelden onder patienten uit deze studie en die uit een parallel studie naar het effect van antidepressiva.

Hoofdstuk 2. De effectiviteit van psychotherapie in de eerste lijn bij patiënten met een depressieve stoornis: een systematisch overzicht.
Om een indruk te krijgen hoe groot het te verwachten effect zou zijn in onze interventiestudie hebben wij een systematische literatuurstudie verricht naar de effectiviteit van psychotherapie bij depressies in de huisartsenpraktijk. We vonden 10 studies bij volwassenen die zich op dit onderwerp richtten, er waren geen studies over ouderen. Het bleek dat gemiddeld gesproken psychotherapie vergeleken met de gebruikelijke zorg door de huisarts effectiever was, maar dat dit effectverschil relatief klein was (effect size 0.3 (95% betrouwbaarheidsin-

terval: 0.1-0.5)). Psychotherapie was in alle studies even effectief als medicatie en Problem Solving Therapie was effectiever dan placebo. We concludeerden dat we waarschijnlijk ook in onze studie een bescheiden therapie-effect zouden kunnen verwachten in vergelijking met de gebruikelijke zorg door de huisarts. Verder vonden we in de literatuur aanwijzingen dat het verschil tussen psychotherapie en de gebruikelijke zorg mogelijk groter is bij patiënten met ernstiger vormen van depressie, dan bij patiënten met lichte depressies.

Hoofdstuk 3. De kosteneffectiviteit van psychologische behandelingen voor depressie in de eerste lijn: een systematische review.
Aangezien wij wilden bestuderen of het haalbaar is om IPT in de eerste lijn te implementeren was de vraag naar de kosten-effectiviteit van een dergelijke interventie bijzonder relevant. We vonden in totaal zes studies, waarvan vijf parallel waren uitgevoerd aan studies beschreven in hoofdstuk 2. Voor kosten-effectiviteits studies wordt veelal een evaluatieperiode van één jaar of meer genomen. Het bleek dat de verschillen in kosten-effectiviteit tussen cognitieve gedragstherapie of counselling met de gebruikelijke zorg door de huisarts niet aantoonbaar waren. In één studie was IPT effectiever dan de gebruikelijke huisartsenzorg, maar ook duurder. Er werden geen significante verschillen in kosten-effectiviteit aangetoond tussen psychotherapie of counselling en antidepressieve medicatie. Bij deze bevindingen moet de kanttekening geplaatst worden dat kosten-effectiviteitsanalyses een specifieke methodologie vragen, waaraan de meeste van deze studies niet voldeden. Zo waren deze studies niet opgezet om een verschil in kosten te kunnen aantonen en waren bijvoorbeeld de patiënten aantallen te klein om significante verschillen te demonstreren. We concludeerden dat er wat betreft de kosten-effectiviteit van de psychologische interventies nog geen duidelijke conclusies getrokken kunnen worden.

Hoofdstuk 4. Patiënt voorkeuren bij de behandeling van depressie in de eerste lijn: een literatuur overzicht.
De mening van de patiënt is van groot belang als het gaat om het implementeren van een bepaalde behandeloptie. Daarom hebben we gezocht naar studies waarin de voorkeuren van patiënten werden onderzocht wat betreft de twee voornaamste behandelopties voor depressie namelijk antidepressieve medicatie en gesprekstherapie. Ook op dit gebied was er weinig over ouderen te vinden, de bevindingen gaan dus voornamelijk over jonger volwassenen of gemengde groepen. In groepen van depressieve patienten gaf 51-69% van de respondenten aan een voorkeur te hebben voor gesprekstherapie, 20-38% had een voorkeur

voor antidepressieve medicatie. In groepen van niet-depressieve respondenten had 32-98% een voorkeur voor gesprekstherapie en 15-35% voor antidepressieve medicatie. Als doorgevraagd werd naar de overwegingen bij deze voorkeuren, bleek dat respondenten vaak onvoldoende geïnformeerd waren over één of beide behandelopties. Hun keuzes waren dus in feite gebaseerd op foutieve aannames. Als patiënten goed voorgelicht waren zoals in sommige interventiestudies, waren de verschillen minder groot, maar nog steeds gaven meer patiënten de voorkeur aan gesprekstherapie. Wij concludeerden uit deze studie dat het aanbieden van psychotherapie in de huisartsenpraktijk aansluit bij de voorkeur van veel patiënten.

Hoofdstuk 5. Is Interpersoonlijke Psychotherapie een haalbare behandeloptie voor depressieve ouderen in de huisartsenpraktijk?
Om te kunnen onderbouwen of het haalbaar is IPT in te voeren, uitgevoerd door GGZ medewerkers in de huisartsenpraktijk, hebben wij de motivatie tot deelname van alle participanten beschreven. Na het afronden van de interventie hebben we alle participanten gevraagd het project te evalueren. Van de 205 patiënten die aan het eind van de screeningsprocedure in aanmerking kwamen voor deelname aan de interventiestudie, was een relatief hoog percentage gemotiveerd: 70%. Van de 69 patiënten die de IPT kregen aangeboden rondde 77% een volledige therapie af. Achteraf beoordeelden de patiënten de behandeling positief. Tweederde van de huisartsen die wij benaderden wilde deelnemen aan het project. Bij de anderen was de voornaamste reden om niet mee te doen een gebrek aan ruimte voor de GGZ therapeut. Achteraf gaven alle huisartsen aan een positieve indruk te hebben van de IPT interventie, 21 van de 22 huisartsen zeiden dat zij gebruik zouden willen maken van de interventie als die ook na het project beschikbaar zou zijn. Voor twee psychologenpraktijken was het niet haalbaar om aan het project deel te nemen, voornamelijk om financiële redenen. De vier benaderde GGZ instellingen wilden allen meedoen als het aantal therapiëen dat de therapeuten geacht werden te doen beperkt bleef, omdat er geen extra financiering voor dit werk beschikbaar was. Na training in IPT van de ouderenteams van deze instellingen bleek de meerderheid van de therapeuten interesse te hebben in IPT en in deelname aan de studie. Achteraf gaven de therapeuten aan dat zij het werk in de huisartsenpraktijk waardeerden, evenals het werken volgens het IPT protocol. In sommige praktijken was het herhaaldelijk moeten zoeken naar een therapieruimte wel interferend.
We concludeerden dat het haalbaar is IPT beschikbaar te maken in de huisartsenpraktijk, zeker ook als IPT kan worden gegeven door sociaal psychiatrisch verpleegkundigen of psychologen die al werkzaam zijn in de huisartsenpraktijken

in het kader van één van de vele eerstelijns consultatieprojecten die in Nederland zijn opgestart.

Hoofdstuk 6. De effectiviteit van Interpersoonlijke Psychotherapie voor depressieve ouderen in de eerste lijn.
Om de effectiviteit van IPT te meten, werden 143 patiënten via loting toegewezen aan òf IPT (N=69) òf de gebruikelijke zorg door de huisarts (N=74). Patienten in de IPT groep kregen 10 sessies IPT aangeboden. Vóór het begin, na twee maanden en na zes maanden werden alle deelnemers geïnterviewd. De belangrijkste uitkomstmaten met betrekking tot het verloop van de depressieve klachten waren: remissie (een score van < 10 op de Montgomery Åsberg Depression Rating Scale, MADRS), diagnose depressie (DSM-IV criteria, gemeten met de PRIMary care Evaluation of Mental Disorders, PRIME-MD) en ernst van de depressie (gemiddelde score op de MADRS of GDS-15). Daarnaast werd ook het algemeen functioneren gevolgd met de Medical Outcome Study 36-item Short Form Health Survey (SF-36).

We vonden dat IPT effectiever was dan de huisartsenzorg in het reduceren van het aantal patiënten met een diagnose depressie (verschil van 17%). De remissie percentages waren in beide condities even laag (32-33%), en ook op de gemiddelde ernstscores werden geen significante verschillen gevonden. De groep completers, patiënten die een IPT behandeling van minimaal 6 sessies kregen, bleken significant meer te verbeteren dan de patiënten uit de controlegroep wat betreft het algeheel psychisch functioneren en wat betreft het sociaal functioneren in het bijzonder. Uit een post hoc analyse bleek dat het effectverschil tussen IPT en de gebruikelijke huisartsenzorg meer uitgesproken was in de groep patiënten die bij aanvang van de studie een matig tot ernstige depressie had (MADRS>20); we concludeerden dat een intensieve interventie als IPT voornamelijk geïndiceerd is voor patiënten met een matige tot ernstige depressie.

Hoofdstuk 7. Predictoren van het beloop van depressie bij ouderen in twee interventie studies in de eerste lijn.
Omdat er veel variatie in uitkomst gevonden wordt in interventiestudies, is een volgende stap in het onderzoek om na te gaan welke variabelen die variatie bepalen. Wij hadden de mogeiljkheid om deze analyses uit te voeren in twee studies die qua opzet identiek waren: de IPT Studie beschreven in dit proefschrift en de West Friesland Studie, waarin een behandeling met antidepressiva (uitgevoerd conform de richtlijn van het Nederlands Huisarts Genootschap) werd

vergeleken met de gangbare huisartsenzorg. Als maten voor de uitkomst van de depressie werden genomen: diagnose depressie (PRIME-MD) en remissie (MADRS <10). We onderzochten de voorspellende waarde van 13 mogelijke predictoren door middel van 'backward logistisic regression'. We vonden dat een hogere leeftijd, een lager educatie niveau, recente ingrijpende levensgebeurtenissen, een lager niveau van sociaal functioneren, een hogere ernst van de depressie, een lager niveau van fysiek functioneren en paniekklachten, een slechtere uitkomst voorspelden. Opvallend was dat IPT effectiever was bij patiënten die recent een ingrijpende levensgebeurtenis hadden meegemaakt, ook was IPT effectiever bij vrouwen dan bij mannen. We concludeerden dat de predictoren die wij bij ouderen vonden overeen kwamen met die in studies bij jongere volwassenen. Patiënten met karakteristieken die een slecht beloop voorspellen moeten zorgvuldig gevolgd en mogelijk eerder verwezen worden.

Hoofdstuk 8. Discussie.
We richtten ons in dit onderzoek dus op twee aangrijpingspunten ter verbetering van de depressie zorg voor ouderen in de huisartenpraktijk, we screenden voor depressie en introduceerden IPT.

Wat betreft de screening: Screening bleek haalbaar als het uitgevoerd werd door onze onderzoeksassistenten. De huisartsen zelf hadden te weinig tijd om dit te doen. Door onze screeningsprocedure, beschreven in hoofdstuk 6, waren we in staat voldoende deelnemers voor ons project te recruteren binnen anderhalf jaar.Ook voorkwamen we door onze werkwijze dat huisartsen selectief zouden verwijzen. Echter, de selectieprocedure gebaseerd op het DSM-IV systeem had een beperking: mogelijk werden hierdoor te veel patiënten geïdentificeerd als lijdend aan een depressieve stoornis, terwijl gemeten met de MADRS, meer dan de helft van deze patiënten slechts een lichte depressie had, beneden de drempel voor 'caseness' (MADRS ≥21). Juist voor deze groep patiënten met licht depressieve klachten bleek IPT weinig toegevoegde waarde te hebben. Deze bevinding raakt aan een knelpunt in de huidige depressie diagnostiek: door alleen symptomen te tellen is de diagnose van depressie mogelijk te veel opgerekt. Weliswaar is aangetoond dat licht depressieve klachten samen gaan met veel beperkingen en een toename in het gebruik van (para)medische voorzieningen, maar in feite zijn deze klachten moeilijker te classificeren. De symptomen kunnen vroege stadia van een ernstiger depressie representeren, maar kunnen ook een reactie zijn op vervelende levensgebeurtenissen of op lichamelijke ziekten. Op basis van prevalentiestudies, die vergelijkbare DSM-IV diagnostiek gebruiken, wordt vaak gesteld dat huisartsen onderdiagnosticeren en onderbe-

handelen, maar het is de vraag of die 'kritiek' terecht is. De tweedelijnsvisie op depressie geldt waarschijnlijk niet voor deze groep patiënten, waarbij de toegevoegde waarde van specifieke depressiebehandelingen beperkt is.

We concluderen dat de door ons gebruikte screeningsprocedure haalbaar en succesvol was voor het recruteren van patiënten voor de interventiestudie. In toekomstig onderzoek naar specifieke depressiebehandelingen in de eerste lijn, is het echter raadzaam om aan de selectieprocedure een maat voor de ernst van de depressie toe te voegen, zodat patiënten met ernstiger vormen van depressie geselecteerd kunnen worden, bij wie specifieke depressiebehandelingen een grotere additieve waarde hebben.

Wat betreft het transmuraal toepassen van IPT: Het uitgangspunt was dat we de expertise in het behandelen van depressie wilden overdragen van de tweede lijn naar de eerstelijns gezondheidszorg door een intensieve samenwerking te realiseren. We concludeerden dat het inderdaad mogelijk is IPT, een therapie ontwikkeld in de tweede lijn, toe te passen in de eerste lijn door GGZ medewerkers te 'detacheren' in de huisartsenpraktijk. Echter, de therapie kon niet zonder meer worden toegepast bij alle eerstelijns patiënten. In het IPT protocol ligt een sterke nadruk op de depressie als ziekte. In de eerste sessie wordt de ziekte depressie centraal gesteld en wordt voorlichting over deze ziekte gegeven. Dit aspect gaf problemen bij de groep patiënten met lichte klachten. Zij herkenden zich niet in het hebben van een ziekte. Ook de therapeuten vonden dat er bij deze mensen niet over een ziekelijke depressie, zoals zij die kenden uit de tweede lijn, gesproken kon worden. Daarom werd al vroeg in het project de strategie bij deze patiënten gewijzigd. Er werd bij hen alleen maar over de klachten gesproken en hoe die in verband stonden met het interpersoonlijk functioneren. Vervolgens kon dan het reguliere IPT protocol gevolgd worden met betrekking tot het zoeken naar het voornaamste probleemgebied en het uitwerken hiervan. Het feit dat deze aanpassing noodzakelijk was illustreert opnieuw dat de groep patiënten met licht depressieve klachten een andere benadering vraagt.

Het implementeren van IPT kan alleen op grotere schaal worden ondersteund als de interventie (kosten)effectief is. In onze studie kon een bescheiden behandeleffect worden aangetoond. Dit resultaat sloot aan op de bevindingen van andere studies naar de effectiviteit van psychotherapie als monotherapie in de eerste lijn (Hoofdstuk 2). We bespraken in Hoofdstuk 6 dat de effectiviteit waarschijnlijk kan worden verhoogd als IPT of een andere vorm van evidence based psychotherapie optimaal wordt uitgevoerd door goed getrainde therapeuten en selectief wordt toegepast. Daarnaast kan de depressiezorg als geheel

verbeteren door de psychotherapie op te nemen in een meer uitgebreid depressiebehandelpakket ter ondersteuning van de huisarts. In een tweetal Amerikaanse projecten, waarin in de eerstelijns praktijk een depressiemanager (spv of psycholoog) actief was, waren de behandeleffecten meer uitgesproken positief (Unützer et al., 2002; Bruce et al., 2004). In dergelijke projecten kunnen patiënten kiezen tussen psychotherapie en medicatie, kunnen zij switchen als de behandeling niet aanslaat of kan er overgegaan worden op een combinatiebehandeling. Op basis van een economische evaluatie van een dergelijke interventie concludeerde men dat deze aanpak een zeer waardevolle investering was voor depressieve ouderen en dat de interventie geassocieerd was met aanzienlijke klinische verbeteringen, terwijl de gezondheidszorgkosten relatief laag waren (Katon et al., 2005).

In Nederland zijn er nog geen depressiemanagers in de huisartsenpraktijken, maar er zijn veel eerstelijns consultatieprojecten opgestart, waarbij psychiatrisch verpleegkundigen of psychologen de huisartsen ondersteunen in GGZ taken. Het is een kleine stap om deze hulpverleners te trainen tot depressie managers die huisartsen bijvoorbeeld ondersteunen in het voorlichting geven over depressie, het monitoren van antidepressiva gebruik en die zo nodig ook IPT kunnen toepassen. Als onderdeel van een dergelijke 'stepped care' strategie kan IPT dan ook zeker een plaats hebben in de eerstelijns depressiezorg.

APPENDIX

IPT voor depressieve ouderen in de huisartsenpraktijk:
Handleiding voor therapeuten

Januari 2004

1. Inleiding

Deze handleiding voor therapeuten is ontwikkeld ten bate van een door ZONmw gesubsidieerd onderzoek naar de haalbaarheid van het transmuraal toepassen van Interpersoonlijke Psychotherapie (IPT) bij depressieve ouderen. De eerste versie van deze handleiding, gemaakt in 2001, is aangepast op basis van de ervaringen opgedaan tijdens het onderzoek (jan 2004).

Praktisch gezien hield dit onderzoek in dat depressieve patiënten in de praktijk van hun huisarts IPT aangeboden kregen, uitgevoerd door therapeuten van de regionale instelling voor Geestelijke Gezondheidszorg. Het project werd uitgevoerd in de periode van December 2000 tot april 2004, in huisartsenpraktijken in Amsterdam en omstreken. De uitvoering was in handen van de Afdelingen Huisartsgeneeskunde en Psychiatrie van het EMGO/ VU medisch centrum te Amsterdam.

Achtergrond van het onderzoek was dat depressies bij ouderen veel voorkomen in de huisartsenpraktijk. De diagnostiek en behandeling, zo blijkt uit epidemiologische onderzoek, kan echter nog aanzienlijk verbeterd, maar de huisartsen zijn al zwaar belast. Het is gewenst dat huisartsen ondersteuning krijgen op GGZ gebied. In de tweede lijn is veel onderzoek gedaan naar effectieve behandelmethodes (psychotherapie en/of medicatie) voor depressies. Psychotherapie en psychofarmaca blijken even effectief te zijn bij niet-psychotische depressies (Schulberg et al., 1998). De effectiviteit van cognitieve therapie (Koder et al., 1996) en interpersoonlijke psychotherapie bij ouderen (Frank et al., 1993) is aangetoond. Er is nog geen vergelijkend onderzoek tussen deze twee vormen van psychotherapie met ouderen beschikbaar. De IPT methodiek is relatief makkelijk aan te leren voor therapeuten met diverse achtergronden en disciplines. De IPT werkwijze sluit ook goed aan bij de problematiek van ouderen. Op interpersoonlijk gebied treden er bij ouderen veel veranderingen op (bijvoorbeeld overlijden van partner, pensionering, gevolgen van lichamelijke ziekte). Deze veranderingen bieden een goed aanknopingspunt voor een geprotocolleerde gesprekstherapie als IPT. Voor een meer uitgebreide toelichting op het project verwijzen wij naar ons artikel in Directieve Therapie (Van Schaik et al., 2003). Daarin wordt ook een overzicht gegeven van het bestaande onderzoek naar de effectiviteit van IPT bij ouderen.

In de eerste Standaard Depressie van het Nederlands Huisartsen Genootschap waren de uitgangspunten voor het beleid dat bij een milde depressie eventueel vervolgcontacten werden afgesproken en bij een ernstige depressie in ieder geval vervolgcontacten en eventueel medicatie (Van Marwijk et al., 1994). Sommige van de ouderen met een depressie willen of verdragen echter geen me-

dicatie en willen ook niet naar de tweede lijn verwezen worden. De kans bestaat dat de behandeling hierdoor in een impasse raakt. Voor deze groep patiënten kan een psychotherapie zoals IPT een adequate oplossing zijn, waarmee het herstel versneld wordt en mogelijke chroniciteit voorkomen kan worden. In de herziene versie van de Standaard Depressieve stoornis is de plaats van psychotherapie meer expliciet aangegeven (Van Marwijk et al., 2003).

Uit het Amsterdamse onderzoek bleek dat patiënten voornamelijk positief waren over de IPT werkwijze. Ook de therapeuten (psychologen en sociaal psychiatrisch verpleegkundigen) die voor het onderzoek in IPT getraind werden en die verschillende therapeutische achtergronden hadden, waren positief over het IPT protocol als middel om een acute depressie te behandelen. Huisartsen hebben zelf beperkte tijd voor gesprekscontacten en velen van hen vinden het prettig dat hun patiënten op deze manier een gerichte behandeling krijgen als de medicamenteuze behandeling niet (voldoende) effect heeft. Training en supervisie in IPT zullen in de toekomst beter toegankelijk worden nu het "Centrum voor Interpersoonlijk Psychotherapie" (Blom en Jonker, Parnassia, Den Haag) is opgericht met onder andere als doel het stroomlijnen van de opleiding tot IPT therapeut en het opleiden van meer supervisoren en trainers in Nederland

2. Wat is Interpersoonlijke Psychotherapie (IPT)?

IPT is een gestructureerde vorm van psychotherapie die, toegepast in de tweede lijn, uit 12-16 sessies bestaat. De therapie is ontwikkeld voor depressieve patiënten. Er wordt uitgegaan van het ziektemodel voor depressie dat wil zeggen dat de depressie expliciet als ziekte benoemd wordt en dat er voorlichting over deze ziekte gegeven wordt. Daarnaast is het uitgangspunt dat depressieve symptomen vaak in verband staan met interpersoonlijke problemen. Aan het begin van de therapie wordt een "interpersoonlijke anamnese" afgenomen waarin wordt nagegaan welke personen belangrijk zijn voor de patiënt en of er spanningen of grote veranderingen in de relaties met belangrijke anderen zijn. Deze inventarisatie leidt tot een behandelfocus.

Het doel is symptoomvermindering en een betere aanpassing aan de huidige levensfase. De benadering is sterk op het hier-en-nu gericht. De (overdrachts)relatie naar de therapeut wordt in principe buiten beschouwing gelaten. Er worden technieken uit verschillende psychotherapeutische stromingen gebruikt.

Voor toepassing in het Amsterdamse eerste lijnsproject is het aantal sessies teruggebracht tot 10. Voor ongeveer 65% van de patiënten in het onderzoeksproject was dit aantal goed volgens de inschatting van de therapeuten. In

ongeveer 20% van de gevallen leken minder sessies noodzakelijk en in 10% zou er voorkeur zijn geweest voor meer sessies. In de praktijk kan een flexibele aanpak gevolgd worden d.w.z. dat met de patiënt besproken wordt dat het aantal therapiesessies afgebakend is, tussen acht en 14 sessies, en dat na vijf sessies afgesproken zal worden welk aantal uiteindelijk gekozen zal worden. Er wordt vastgehouden aan de structuur van IPT wat betreft de opbouw in drie fasen, de variatie wordt vooral bepaald door de duur van de behandelfase:

Fase 1. Diagnostiek en uitleg (sessies 1-3). De therapeut maakt een inventarisatie van de depressieve symptomen en geeft voorlichting over de ziekte depressie en de behandeling. Vervolgens wordt de interpersoonlijke anamnese afgenomen en wordt er een behandelfocus vastgesteld.

*Fase 2. Behandeling (*sessies 4-8). Eén van de volgende vier interpersoonlijke focussen wordt uitgewerkt:

- Rouw
- Interpersoonlijk conflict
- Rolverandering
- Interpersoonlijk tekort, ook wel interpersoonlijke sensitiviteit genoemd.

Fase 3. Afsluiten van de behandeling (sessies 9 en 10). Het afronden van de therapie wordt besproken, er wordt geanticipeerd op eventuele problemen in de toekomst en op vroege herkenning van eventuele depressieve klachten. De behandeling wordt geëvalueerd.

Alhoewel IPT ontwikkeld is voor de behandeling van een depressieve stoornis bij volwassenen, is er inmiddels met meerdere aangepaste versies onderzoek gedaan. Naast onderzoek bij ouderen met een depressie is IPT ook onderzocht bij adolescenten (Mufson et al., 1993), bij patiënten met een dysthyme stoornis (Markowitz, 1997) en bij patiënten met recidiverende depressies (Reynolds, et al., 1999), als onderhoudsbehandeling. Verder is IPT effectief gebleken bij patiënten met boulimia nervosa (Fairburn et al.,1993).

3. Het behandelprotocol

In de studies waarin de werkzaamheid van IPT werd aangetoond vonden de sessies wekelijks plaats. Het is de vraag of dit in de gewone praktijk haalbaar en wenselijk is. Het lijkt van belang om intensief te starten zodat een goede werkrelatie kan ontstaan. In het Amsterdamse onderzoek werd de volgende sequentie nagestreefd: vier maal één keer per week, vier maal één keer per twee weken en twee maal één keer per maand. Voor de duur van de sessies wordt 35-45 min gerekend.

Voor de navolgende uitwerking van de behandelrichtlijnen is gebruik gemaakt van het protocol "Interpersoonlijke psychotherapie" (Blom & Jonker, 1999) en van "IPT in the Treatment of late life Depression" (Frank et al., 1993).

3.1 Diagnostiek en uitleg

Doelen van deze fase:

- de depressie bespreken
- de interpersoonlijke anamnese afnemen en de depressie relateren aan de interpersoonlijke context
- de grootste probleemgebieden identificeren
- de IPT concepten en het contract uitleggen

Sessie 1. In de eerste sessie wordt ingegaan op hoe de verwijzing tot stand is gekomen en wordt besproken of het doel hiervan voor de patiënt duidelijk is. Als de patiënt vooraf informatie over de therapie heeft gehad is het zinnig na te gaan of hij/zij deze informatie gelezen heeft en of er nog vragen zijn. Als er duidelijke weerstand van de patiënt is dient hierop te worden ingegaan. Meestal lukt het wel om misverstanden of vooroordelen ("ik wil niet alles van vroeger oprakelen") te bespreken zodat deze geen interfererende rol meer spelen.

Over de depressie: de patiënt wordt gevraagd zijn/haar klachten te beschrijven en specifieke kenmerken van de depressie worden gericht uitgevraagd. De therapeut vat de klachten samen en plaatst deze binnen het kader van de depressieve stoornis. Het beloop van de depressieve klachten bij deze patiënt, inclusief eerdere episodes, en beïnvloedende biologische factoren (familieanamnese, medicatie, alcohol, somatische aandoeningen) wordt verder uitgevraagd. Ook over de depressie heeft de patiënt mogelijk voorlichtingsmateriaal ontvangen (bijvoorbeeld de NHG folder) ontvangen. Naar aanleiding hiervan kan nagegaan worden wat de patiënt van de ziekte depressie weet en kan er zo nodig aanvullende informatie gegeven worden. Het is belangrijk zelfbeschuldigende reacties die vaak bij een depressie voorkomen, vanaf het begin te neutraliseren.

In het Amsterdamse project bleek dat veel therapeuten gewend zijn meteen in te gaan op de levensproblemen die de patiënt inbrengt. Het is voor de IPT strategie echter van belang dat de therapeut steunend is, maar ook sturend in de gesprekken. Met interventies als "Het is duidelijk dat de ruzies met uw man u erg in beslag nemen. We zullen daar ook nog uitgebreid op terugkomen, maar in dit eerste gesprek wil ik vooral aandacht besteden aan uw depressieve klachten" moet getracht worden in de eerste fase díe onderwerpen aan bod te laten komen die op dat moment belangrijk zijn binnen de IPT strategie. Ook bleek dat een aantal patiënten moeite had met de term depressie. Voor sommigen is dit een zeer beladen term. Het is van belang die lading te exploreren. Als de patiënt zich hoe dan ook van de term blijft distantiëren, of als er in feite sprake is van een zeer lichte depressie, kan men het beste aansluiten bij de terminologie van de patiënt.

Eventueel kan in de eerste sessie al gestart worden met de interpersoonlijke anamnese. Aan het eind van het eerste gesprek worden bij voorkeur een serie vervolgafspraken gepland, zo mogelijk op een vaste therapietijd in de week.

Sessie 2-3. Na de eerste sessie start de therapeut alle volgende sessies met: "Hoe is het deze week gegaan?" Daarmee wordt de aandacht van de patiënt direct gericht op de wereld buiten de therapie. In het begin van de behandeling zal de patiënt vaak zijn of haar klachten naar voren brengen. De therapeut heeft een empathische houding en benoemt de klachten als (nog) duidelijk aanwezig zijnde symptomen van de depressie. Aangezien er in het eerste gesprek uitvoerig aandacht is besteed aan de depressieve klachten, hoeven deze niet iedere keer opnieuw uitvoerig besproken te worden. Het is wel van belang steeds de relatie tussen het beloop van de klachten en interpersoonlijke voorvallen te exploreren en te verduidelijken. Op die manier leert de patiënt het verband te zien tussen gebeurtenissen in de relatie met belangrijke anderen en de stemming.

Het kan soms moeite kosten de beschrijving van de ervaringen in de afgelopen week af te bakenen. Dit geldt zeker bij ouderen die regelmatig ingrijpende voorvallen, met name rondom ziekte van henzelf of naasten meemaken. Van de therapeut wordt een steunende, maar ook actief structurerende houding verwacht, die waarborgt dat de IPT strategie wat betreft de inhoud en opbouw van de gesprekken gevolgd wordt. Dus als de patiënt bijvoorbeeld vertelt over een spannend bezoek aan een arts wordt daar op steunende wijze op ingegaan. In principe wordt altijd nagegaan hoe een dergelijke gebeurtenis van invloed was op de depressieve klachten. Ook wordt besproken bij wie de patiënt steun heeft gezocht. Vervolgens wordt het gesprek weer teruggebracht naar de IPT benadering. Dus bijvoorbeeld "Het is wel duidelijk dat het nu extra moeilijk is met dit

soort spanningen om te gaan, omdat uw psychische weerstand verminderd is door de depressie. Het doel van onze gesprekken hier is aan die depressie iets te verbeteren. Vorige keer bespraken we... en nu wil ik verder met u gaan over…".

Het is de bedoeling dat in het tweede en derde gesprek een nauwkeurige inventarisatie van het sociale netwerk van de patiënt plaatsvindt. Wie zijn belangrijke personen in het leven van de patiënt, wat is de aard van de relatie, wat zijn wederzijdse verwachtingen en mogelijk recente veranderingen in de relatie? Als het sociale netwerk erg uitgebreid is, bijvoorbeeld bij ouderen met veel kinderen en kleinkinderen, kan alleen ingegaan worden op de meest belangrijke contacten (in positieve of negatieve zin). Samenvattend is de interpersoonlijke anamnese er op gericht díe interpersoonlijke gebeurtenis(sen), of díe specifieke relatie(s) te vinden die het meest van invloed zijn op de klachten.

Bij ouderen kunnen er twee kanttekeningen gemaakt worden bij de interpersoonlijke inventarisatie:

- Ouderen kunnen een vrij geïsoleerd bestaan leiden. Alhoewel IPT in principe op het hier en nu gericht is kan dit een reden zijn om toch vooral op interpersoonlijke gebeurtenissen uit het verleden in te gaan. Dit is noodzakelijk om een indruk te krijgen van hoe de patiënt met anderen omgegaan is. Het is verder belangrijk om na te gaan of het gebrek aan contacten veroorzaakt is door reële verliezen in de laatste jaren of dat er sprake is van persoonlijkheidsproblematiek en dus, in IPT termen, van interpersoonlijke tekortkomingen.
- Als de ouderen een uitgebreid (familie)netnetwerk hebben kan een geno- of sociogram nuttig zijn.

Aan het eind van het derde gesprek vat de therapeut de bevindingen uit de interpersoonlijke anamnese samen en legt voor aan de patiënt wat hij/zij als belangrijkste luxerende of onderhoudende factor van de depressieve klachten ziet. Als de patiënt zich in deze samenvatting kan vinden wordt afgesproken dat dit het behandelfocus wordt. Het is vaak niet noodzakelijk de IPT termen voor het focus (bijvoorbeeld "interpersoonlijk conflict" of "rolverandering") te gebruiken. Men kan meestal volstaan met de termen die de patiënt zelf gebruikte. Het kiezen van het focus gaat dus wel in overleg, maar de therapeut neemt het initiatief. Meestal is de patiënt het met het voorstel van de therapeut eens. Soms zijn er meerdere focussen aan te geven. In overleg met de patiënt wordt dan het meest geschikte focus gekozen. Een enkele keer komt het voor dat de patiënt een ander focus wil bespreken dan de therapeut. Het is weinig therapeutisch de patiënt een focus op te dringen, het is beter in een dergelijke situatie aan te sluiten bij de keuze van de patiënt met de kanttekening dat er later in de therapie alsnog overgegaan kan worden op het andere focus, als de gekozen aanpak

te weinig resultaat geeft. Bij ouderen is het advies dàt focus te nemen waar vrij snel verbetering lijkt te kunnen worden bewerkstelligd, aangezien een gevoel van hopeloosheid kan overheersen en snelle verbetering op een bepaald punt weer hoop kan geven.

Overigens werd in het Amsterdamse onderzoek het focus rolverandering (vooral de rolverandering van actieve gezonde persoon naar iemand met beperkingen door lichamelijke ziekte) het meest gekozen, daarna interpersoonlijk conflict en daarna rouw. Deze verdeling sloot aan bij bevindingen in de literatuur over IPT bij ouderen(Miller et al., 2001). Interpersoonlijk tekort wordt zelden als focus gekozen.

Voorbeeld van het kiezen van een focus:

Therapeut:	*U vertelde mij dat u steeds somberder werd nadat u was verhuisd, begreep ik dat goed?*
Patiënt:	*Ja, dat klopt wel, maar ik begrijp niet waarom. Ik wilde die flat juist heel graag.*
Therapeut:	*Ja, want uw wilde graag dichter bij uw kinderen wonen. U heeft verteld dat uw kinderen het druk hebben en dat u ze minder ziet dan u gehoopt had. Na de verhuizing bent u ver van uw oude buurt komen te wonen. U had daar veel contacten, een kaartclubje en goede buren. Die contacten bent u zo goed als kwijtgeraakt.*
Patiënt:	*Ja, ik zie sommigen nog wel, maar een stuk minder.*
Therapeut:	*Ja, uw leven is er heel anders uit komen te zien, u bent veel vaker alleen en dat valt u niet mee. Ik denk dat uw depressieve klachten sterk in verband staan met deze veranderingen. Wat denkt u daarvan?*
Patiënt:	*Ja, dat heb ik eigenlijk ook al gedacht, maar ja, ik kan niet meer terug.*
Therapeut:	*Nee, ik denk ook niet dat dat de beste oplossing is maar we kunnen de recente veranderingen in uw leven wel bespreken en kijken wat voor oplossingen er te bedenken zijn zodat het beter met u gaat. Wat denkt u daarvan?*
Patiënt:	*Ja, dat wil ik wel proberen.*

(Het focus bij deze therapie wordt dus rolverandering, de aanpassing na de verhuizing).

In deze eerste fase van de behandeling wordt door gericht te vragen aan de patiënt impliciet duidelijk gemaakt wat de bedoeling is, vooruitlopend op de behandelfase. De patiënt wordt verder uitgelegd dat hij/zij in de volgende gesprekken de onderwerpen kiest en wordt aangemoedigd te praten over de dingen die hij/zij meemaakt (met anderen).

3.2 De behandelingsfase

In de behandelingsfase (sessies 4-9) wordt het gekozen focus uitgewerkt. Elk gesprek start ook in deze fase met: 'hoe is het deze week met u gegaan?' Hieronder volgt een bespreking van de focussen.

3.2.1 Focus Rouw

In het algemeen wordt binnen IPT alleen het focus rouw gekozen als er een directe relatie lijkt te zijn tussen de depressie en het overlijden van een belangrijke ander. Bij ouderen wordt het focus rouw ook gekozen als er niemand is overleden, maar als er rouw is om een dementerende of ernstig zieke partner met wie geen of nauwelijks contact meer te krijgen is. Doel van de behandeling is vermindering van de depressieve symptomatologie door het rouwproces te faciliteren. Daarnaast wordt het opbouwen van activiteiten en sociale contacten die het verlies enigszins kunnen compenseren, aangemoedigd.

Het kan voorkomen dat de depressieve reactie veroorzaakt lijkt door een relatief licht verlies bijvoorbeeld het overlijden van een verre kennis, terwijl eerdere grote verliezen goed opgevangen werden. In dat geval is het belangrijk ook aandacht aan de eerdere verliezen te besteden.

De therapeut begint naar relatief 'veilige' onderwerpen te vragen, bijvoorbeeld naar de persoon van de zieke/overledene en ervaringen en gebeurtenissen verder in het verleden. Geleidelijk worden meer belastende onderwerpen nagevraagd totdat uiteindelijk ervaringen en emoties rond het eventuele ziekbed, het afscheid en de begrafenis of crematie aan bod komen. Als de patiënt erg geremd is in het uiten van emoties kan de therapeut hem of haar vragen foto's van de overledene of zieke mee te nemen naar de therapie. Ook kan getracht worden meerdere zintuiglijke ervaringen (horen, zien, voelen, ruiken) bij de beschrijvingen te betrekken zodat een levendige herinnering ontstaat. IPT is geen cathartische therapie in díe zin dat van het uiten van emoties, een heilzame werking wordt verwacht. Bij ouderen is in dit opzicht sowieso enige terughoudendheid op zijn plaats. Het is in ieder geval belangrijk dat de patiënt verschillende gevoelsmodaliteiten (verdriet, woede, schaamte) leert herkennen en ermee leert omgaan. Als de emotionele beleving te sterk wordt is het goed om steunend/

structurerend in te grijpen bijvoorbeeld door de sessie even te onderbreken.

Het is van belang duidelijk te maken dat sterk emotionele reacties bij normale rouw horen. Het gevoel gek te worden of de angst alle controle te verliezen moet benoemd worden. Door het geven van voorlichting over emoties kan de patiënt meer controle gaan ervaren. Als te verwachten is dat in een sessie heftige gevoelens aan bod zullen komen kan worden geanticipeerd op hoe de patiënt eventuele steun na de sessie kan organiseren bijvoorbeeld door een afspraak bij een vriendin te maken.

Voorbeeld van hoe in te gaan op het affect bij een patiënte met rouwproblematiek:

Therapeut:	*Kunt u mij vertellen wat er gebeurde tijdens de begrafenis van uw man?*
Patiënte:	*Het ging eigenlijk best goed.*
Therapeut:	*Wat ging er best goed?*
Patiënte:	*Ik had me voorgenomen bij het graf een toespraak te houden en dat is gelukt. Ik huilde zelfs niet eens en kreeg complimentjes dat ik zo sterk was.*
Therapeut:	*Weet u nog wat er door u heen ging toen u bij het graf stond?*
Patiënte:	*Nou, eigenlijk weinig, ik wilde perse de toespraak houden. Het leek wel of ik verdoofd was, ik voelde niets. Vlak daarna voelde ik me wel heel verlaten van iedereen. Ik heb ook niemand echt gesproken. Ik liet alles maar over me heen komen.*
Therapeut:	*U wilde perse sterk zijn en sloot u eigenlijk af van anderen?*
Patiënte:	*ja*
Therapeut:	*maar u voelde u ook erg alleen met uw verdriet?*
Patiënte :	*Ja, ik heb er eigenlijk sowieso met niemand over gepraat, maar als u er zo naar vraagt.. (huilt).*
Therapeut	*(na korte stilte) Kan u aangeven wat u nu vooral verdrietig maakt?*
Patiënte:	*… alles. Ik denk aan dingen die ik samen met mijn man deed en die ik nu zo mis.*
(Deze worden verder uitgewerkt. Daarna:)	
Patiënte:	*Het is toch niet normaal dat ik toen niet moest huilen en nu wel?*
Therapeut:	*Ik denk dat er verschillende manieren zijn om met verdriet om te gaan. Tijdens de begrafenis wilde u sterk zijn en hield u*

	uw gevoel weg. Daardoor kon u de toespraak houden en kreeg u zelfs complimenten dat u zo sterk was. Nadeel daarvan was dat u zich in uw verdriet alleen voelde.
Patiënte:	*Ja. (stilte)*
Therapeut:	*Hoe is het voor u nu hierover met mij te praten?*
Patiënte:	*Het lucht me wel op.*
	(de therapeut gaat hierop verder in)

De therapeut geeft dus aan dat er geen ideale manier is van omgaan met emoties is, maar dat er verschillende manieren zijn. Het wisselen tussen "contentaffect" ("Wat deed het u toen en daar") en procesaffect ("Hoe is het voor u nu u het hier vertelt?") helpt om dit te illustreren. Eén van de meest krachtige interventies in IPT is het geven van hoop. De therapeut moet duidelijk maken dat verbetering mogelijk en waarschijnlijk is. Benadrukt wordt daarbij dat rouwen een cyclisch proces is. Er blijven momenten terugkomen die herinneringen en emoties oproepen, bijvoorbeeld de verjaardag en de sterfdag. Deze verdrietige perioden worden afgewisseld met perioden waarin het leven weer wat makkelijker gaat.

Nadat een nauwkeurige reconstructie is gemaakt van de verloren relatie en alles wat daarmee samenhing, komt er meer ruimte in de therapie om het toekomstperspectief bij de behandeling te betrekken en de aandacht te richten op het vinden van een nieuwe en zinvolle invulling voor datgene wat men is kwijtgeraakt. Met het overlijden of een langdurig ziekbed van een belangrijk ander vervalt immers niet alleen het contact met die persoon, maar vaak worden ook allerlei andere sociale bindingen minder. Als een vrouw vroeger met haar man naar een kaartclub ging, maar nu ook daar haar overleden partner mist, is de kans groot dat zij niet meer naar die bijeenkomsten zal gaan. De introductie van dit deel van de therapie gebeurt met de nodige voorzichtigheid. Men heeft immers meestal al te vaak gehoord dat hij of zij het verleden van zich af moet zetten en iets nieuws moet gaan doen. Belangrijk is dat de patiënt zich realiseert dat het nooit meer zal zijn zoals het was. De daarmee verbonden connotatie dat het leven over is en nooit meer zinvol zal worden moet echter bestreden worden. Er wordt geëxploreerd wat de behoeftes en wensen van de patiënt zijn en hoe die te verwezenlijken zijn. Het weer opzoeken van oude kennissen en familie is meestal (voor een deel) wel haalbaar. Zo mogelijk wordt de patiënt ook aangemoedigd nieuwe sociale contacten aan te gaan. De therapeut kan suggesties of adviezen geven. Ook het weer opstarten van oude hobby's is vaak

haalbaar. Soms komt de patiënt toe aan interesses of bezigheden die toen de partner nog leefde moeilijk waren, bijvoorbeeld reizen als de partner daar een hekel aan had.

Voorbeeld van probleem oplossende strategie

Therapeut:	*Dus, als ik het goed begrijp zit u het grootste deel van de tijd alleen thuis?*
Patiënt:	*Ja, in de jaren dat mijn man ziek was zijn we steeds meer contacten kwijtgeraakt.*
Therapeut:	*Toen uw man nog gezond was, wat deed u dan zoal samen?*
Patiënt:	*We tennisten en speelden bridge op de tennisclub*
Therapeut:	*Wat denkt u ervan om weer te gaan tennissen of bridgen?*
Patiënt:	*Tja, ik heb daar wel over gedacht, maar ik zie er erg tegenop om daar alleen naar toe te gaan.*
Therapeut:	*Dat is ook heel moeilijk, maar zijn er misschien mensen van de tennis waar u nog contact mee heeft gehouden?*
Patiënt:	*Nee, ik had een goede vriendin die hier ook wel thuis kwam, maar ze had haar eigen problemen en het contact is verwaterd.*
Therapeut:	*Zou u weer contact met haar willen zoeken?*
Patiënt:	*Ja, dat zou ik eigenlijk best kunnen doen. Ik weet niet eens of zij nog tennist. .*

De therapeut stimuleert de patiënt dus weer activiteiten op te starten. Er wordt benadrukt dat dit heel belangrijk is voor een goed herstel van de ziekte. Bij patiënten bij wie “rouw” het focus van de behandeling is, is er vaak een periode geweest waarin zij soms jarenlang overbelast waren ten gevolge van de zorg voor de zieke partner (of andere naaste). De therapeut benadrukt dat de patiënt nu toe mag komen aan eigen behoeftes en wensen. IPT richt zich op de behandeling van de depressie en beperkt zich tot het op gang brengen van een vastgelopen rouwproces. Is dat eenmaal gebeurd dan kunnen normale gevoelens van verdriet weer naar boven komen. Het is belangrijk de patiënt uit te leggen dat een normaal rouwproces over het algemeen veel langer duurt dan de maanden die de behandeling met IPT duurt en dat het normaal is daarna nog regelmatig verdriet te voelen.

3.2.2 Focus Interpersoonlijk conflict

Meestal gaat het bij dit focus om een conflictueuze relatie met de partner. Het belangrijkste conflict waarin iemand verwikkeld is kan echter ook zijn met een kind, ouder of werkgever. Het eerste doel is het conflict te identificeren en te actualiseren. Het moet duidelijk zijn met wie het conflict zich afspeelt.

Met de term interpersoonlijk conflict binnen IPT wordt niet zozeer een patroon bedoeld waarin de patiënt herhaaldelijk in conflicten raakt met mensen om haar of hem heen, maar het gaat om één conflict met één belangrijke persoon. Als een interpersoonlijk conflict een rol speelt bij de actuele depressie, is er meestal sprake van een impasse in het conflict. Ofwel er zijn zoveel hoogoplopende ruzies dat de spanning haast onverdraaglijk wordt òf er zijn geen ruzies meer, maar men leeft in een koude oorlog met elkaar. Eerdere onderhandelingen zijn mislukt.

Als er hoogoplopende ruzies zijn moet getracht worden een "staakt-het-vuren" te bewerkstelligen door bijvoorbeeld te adviseren een tijdje zoveel mogelijk bij elkaar uit de buurt te blijven. Als er geen discussies meer zijn worden de verschillen door de therapeut aangescherpt. Het doel is in beide situaties het conflict weer in de onderhandelingsfase te brengen. Om een indruk te krijgen van de aard van het conflict wordt getracht een zo concreet mogelijk beeld te krijgen van de communicatiepatronen die in het conflict gebruikt worden. Aan de hand van voorbeelden wordt dit goed uitgevraagd bijvoorbeeld wie wat zei en wat de ander toen zei (communicatie analyse).

Voorbeeld communicatie analyse

Therapeut:	*U vertelde me dat u gisteren een nare dag had omdat u weer ruzie had met uw man. Kunt u aangeven hoe dat precies ging?*
Patiënt	*Zoals ik al eerder vertelde klaagt mijn man de laatste jaren altijd over zijn rug. Hij kan dit niet meer en dat niet meer, ik word er gek van! Gisterenochtend was ik gaan winkelen met mijn dochter. Mijn man zou het huis een beetje opruimen, maar hij bleek dit natuurlijk weer eens niet gedaan te hebben.*
Therapeut:	*Dus u zag dat toen u thuis kwam en wat gebeurde er toen?*
Patiënt	*Niets. Hij zat in zijn stoel en deed of er niets aan de hand was. Ik ben meteen gaan opruimen, maar ik kreeg zo'n hoofdpijn dat ik 's middags in bed ben gaan liggen. Toen ik weer beneden kwam vroeg hij me of ik even de krant wilde halen.*

	Dat was voor mij de druppel. Ik ben naar de keuken gegaan en heb niets meer gezegd.
Therapeut:	*En wat gebeurde er toen?*
Patiënt	*Hij kwam na een tijdje achter me aan en vroeg waarom ik in de keuken ging zitten. Toen heb ik voor de zoveelste maal tegen hem gezegd, dat hij nooit iets doet en dat ik zijn voetveeg niet ben.*
Therapeut	*En wat zei uw man toen?*
Patiënt	*Dat hij er niets van begreep, dat hij me chagrijnig vindt de laatste tijd en dat hij nou eenmaal minder kan door zijn rug. Toen hij daar weer over begon heb ik gezegd dat hij altijd zeurt over zijn rug, maar dat hij nooit iets gedaan heeft om mij te helpen in de huishouding en eigenlijk sowieso niet. Ik kan er niet meer tegen, ik heb gedreigd dat ik weg zal gaan.*

Als duidelijk is hoe de problematische communicatie verloopt, hoe de patiënt dit ervaart en wat hij/zij al geprobeerd heeft, wordt vervolgens gestart met het zoeken naar nieuwe oplossingen. Verschillende opties om op een andere manier met de partner te communiceren worden nagegaan. Bij elke mogelijkheid die besproken wordt, wordt zorgvuldig nagegaan of het iets oplevert: 'als u aan uw man vraagt om de afwas op woensdag te doen in plaats van boos op bed te gaan liggen, hoe zou dat voor u zijn? Wat zou u dan precies willen zeggen?' Er kan worden geoefend in een rollenspel. Nadat de patiënt oefent: 'en hoe voelt dat, als u het zo zegt?' Het is belangrijk dat er altijd een concrete situatie wordt besproken. Rollenspelen zijn niet noodzakelijk, maar kunnen een goede aanvulling zijn. De patiënt moet het gevoel krijgen over meerdere mogelijkheden te beschikken om met een bepaalde situatie om te gaan. Als in deze fase van de behandeling de patiënt gaat experimenteren met gedragsopties zal de therapeut in principe elke actie aanmoedigen. "Als het lukt is het mooi, als het niet lukt zullen we de volgende keer bekijken wat er precies gebeurde, daar leren we van."

Het is vaak zinvol de partner bij de behandeling te betrekken. Er kan dan uitleg over de depressie worden gegeven en er kan gezamenlijk worden ingegaan op de communicatieproblemen. Eventueel kan bepaald gedrag geoefend worden. IPT is echter geen relatietherapie in de klassieke zin. De therapeut is niet neutraal en neemt nadrukkelijk positie achter de patiënt. Er is overigens ook een aanpassing van het IPT protocol gemaakt voor een relatiebehandeling (IPT-CM; Conjoint IPT for depressed patients with marital disputes), beschre-

ven in de Comprehensive Guide to IPT van Weissman et al. Het gaat hierbij om een relatietherapie, gebaseerd op de IPT principes. Hiermee is in het Amsterdamse project niet gewerkt.

Bij ouderen kan het moeilijk zijn de communicatiepatronen te veranderen. Als dat na enkele pogingen tot verandering het geval blijkt wordt de strategie aangepast. Mogelijke andere oplossingen worden besproken zoals de consequenties van een eventuele relatiebreuk. In deze levensfase wordt daarvoor vaak niet gekozen, omdat de voordelen van een eventuele scheiding in deze levensfase niet opwegen tegen de nadelen. Dit inzicht kan de patiënt helpen een meer accepterende houding ten aanzien van de situatie te ontwikkelen. Er wordt gekeken naar manieren om afleiding te vinden, of, zo mogelijk worden ook de meer positieve kanten van de partner belicht. Kortom het doel wordt hoe het mogelijk is binnen de huidige relatie er het beste van te maken.

3.2.3 Focus interpersoonlijke rolverandering

Bij dit focus is er een belangrijke verandering in het leven van de patiënt geweest voorafgaand aan de depressie. Bij ouderen gaat het vaak om pensionering, verhuizing, grootouder worden en omgaan met ziekte of beperkingen.
De therapeut start met het exploreren van de recente veranderingen. Zoals ook bij de andere focussen werd genoemd is het van belang zo gedetailleerd mogelijk op de verandering in te gaan, zodat er een concrete beschrijving ontstaat, meestal van wat men allemaal (vooral op het gebied van sociale contacten) is kwijtgeraakt. Zoals steeds bij IPT is het van belang nadrukkelijk in te gaan op de affecten die bij de verschillende situaties een rol speelden of die nu tijdens de sessie een rol blijken te spelen. Het is een belangrijk onderdeel van de therapie dat patiënten verschillende soorten gevoelens leren herkennen en ook voor zichzelf serieus nemen. Vaak is voor de patiënt het verband tussen de depressie en de verandering in hun leven, maar beperkt duidelijk. Het uitwerken van de situatie kan het hopeloze, machteloze gevoel van de depressie naar de achtergrond doen verdwijnen. Er ontstaat dan meer mogelijkheid om aan de hand van de concrete situatie naar oplossingen te gaan zoeken.

Voorbeeld rolverandering

Therapeut:	*U zegt dat u eigenlijk niet begrijpt waarom u depressief bent geworden. Er zijn geen vervelende gebeurtenissen geweest.*
Patiënte:	*Nee, ik begrijp het niet.*
Therapeut:	*U heeft verteld dat de klachten in het afgelopen half jaar*

ontstaan zijn. Wat heeft u zoal meegemaakt in het afgelopen half jaar, zijn er dingen in uw leven veranderd?

Patiënte: *Ja, dat wel. We hebben vier maanden geleden onze winkel verkocht, We hebben er veel geld aan overgehouden, dus dat is niet iets om somber over te worden. Ik had me er juist erg op verheugd een rustiger leven te hebben, maar nu heb ik er niets aan, want ik zit maar voor me uit te staren.*

Therapeut: *Ja, de depressieve klachten beperken u erg. Wat u nu vertelt, het verkopen van de winkel en de veranderingen die hiermee gepaard zijn gegaan kan wel een grote invloed hebben op uw klachten. Kunt u iets meer vertellen over hoe uw leven veranderd is?*

(Patiënte vertelt over de tijd dat ze de winkel nog hadden. Ze wordt levendiger en beschrijft hoe de zaak steeds mooier geworden was in de loop der jaren, dat ze veel tevreden klanten hadden, dat er zelfs bij waren die 35 jaar klant waren geweest. Ze waren eigenlijk altijd met de zaak bezig geweest, omdat er ook buiten de openingstijden veel te doen viel. Al vertellend wordt het patiënte ook duidelijk dat ze veel uit die tijd mist, vooral het contact met de klanten. Dit was iets waar ze eigenlijk niet bij stil had gestaan temeer daar haar man alleen maar blij lijkt te zijn dat de zaak is verkocht. Hij heeft een stuk grond gekocht en is heel actief met tuinieren. Het blijkt echter dat patiënte zelf nog geen andere invulling heeft en nu veel alleen thuis zit. Ze mist activiteiten die haar voldoening geven).

Nu de probleemsituatie en het bijbehorende gevoel duidelijk is kan verder gegaan worden met het zoeken naar oplossingen. Interessegebieden, wensen en mogelijkheden van de patiënt worden nagegaan. Vervolgens wordt de patiënt aangemoedigd activiteiten en contacten op te bouwen, waardoor hij/zij zich beter kan aanpassen aan de verandering in zijn/haar leven. Bij iedere stap die de patiënt zet wordt geëvalueerd hoe dat gegaan is. Eventueel wordt gewerkt met opdrachten.

Vervolg voorbeeld rolverandering

De depressieve klachten van patiënte nemen af nu zij meer verband ziet tussen haar klachten en de huidige levensfase; ze ervaart de depressie niet meer als iets wat haar zo maar overkomen is. Zij is het er mee eens dat zij eigenlijk

meer activiteiten zou moeten hebben, want alleen zijn is niets voor haar. Samen met haar wordt gekeken wat zij zou kunnen gaan doen. Ze zou eigenlijk best vaker op de kleinkinderen willen passen, maar dat kon voordien nooit en nu hebben de kinderen andere oplossingen gezocht. Ze wordt aangemoedigd dit eens met haar kinderen te bespreken. Aangezien ze creatief is wordt ze aangemoedigd in een buurtcentrum te informeren wat de mogelijkheden zijn. Verder heeft ze ooit in een koor gezongen, maar is daarmee gestopt toen ze zwanger was van haar eerste kind. Hoe de verschillende stappen verlopen wordt nabesproken en eventueel aangevuld met andere suggesties of opdrachtjes "zullen we afspreken dat u deze week die kennis belt die in dat koor zingt, zodat u eens kan horen hoe het gaat in dat koor en wat men verwacht van koorleden? U kan dan duidelijker afwegen of het u iets lijkt".

Bij sommige patiënten ontbreken de vaardigheden om uit zichzelf te experimenteren in de nieuwe rol. Rollenspelen kunnen dan zinvol zijn. Overigens wordt sowieso ook weer ingegaan op hoe de patiënt zich voelt bij de verschillende stappen. Onzekerheden of twijfels worden besproken. De rol van de therapeut is in feite die van een coach, die aanmoedigt en adviezen geeft.

3.2.4 Focus Interpersoonlijke tekorten

Van een interpersoonlijk tekort is sprake als de patiënt duurzaam moeite heeft met het aangaan of onderhouden van betekenisvolle relaties. De behandeling is gericht op het vergroten of verbeteren van het sociaal netwerk. Vaak kiest men dit focus als men niet kan uitkomen met één van de drie andere focussen. Volgens Markowitz (1997) zijn er aanwijzingen dat patiënten die met dit focus behandeld worden minder goed reageren op IPT. Dat heeft wellicht te maken met het feit dat IPT beter werkt als er sprake is van een redelijk intact sociaal netwerk. Bij patiënten waar dat netwerk niet of nauwelijks aanwezig is, zal IPT een minder grote kans van slagen hebben. Er is bij dit focus per definitie sprake van een arm sociaal netwerk zodat de therapeut vaak de therapeutische relatie zelf moet gebruiken als model- en oefensituatie. In die zin wijkt de werkwijze dus af van wat bij IPT gebruikelijk is namelijk dat de therapeutische relatie nauwelijks in de therapie betrokken wordt en dat de aandacht vooral gericht wordt op wat er gebeurt buiten de spreekkamer, in contacten met anderen.

Na het vaststellen van het focus, gaat de therapeut zorgvuldig na hoe relaties in het verleden verlopen zijn. De therapeut gaat na welke sociale contacten er geweest zijn, hoe deze begonnen en hoe ze weer afliepen, wat de positieve en

wat de negatieve kanten waren. Bij deze inventarisatie wordt nauwkeurig gelet op patronen die zich hierbij voordeden: is de patiënt iemand die snel geneigd is om zelfs bij verdenking op krenking, het contact te verbreken? Of is het juist iemand die steeds afgewezen wordt en klagend alleen achterblijft? Het is belangrijk er op bedacht te zijn dat patronen die zich in veel van de eerdere relaties hebben voorgedaan, zich ook in de sessies kunnen manifesteren. Positieve en negatieve gevoelens ten opzichte van de therapeut moeten eventueel in een vroeg stadium besproken worden en het streven is dat de patiënt oog krijgt voor de parallel tussen de gevoelens over de therapeut en die in andere relaties. Op deze wijze wordt getracht problemen binnen de werkrelatie hanteerbaar te houden en de patiënt zicht te geven op zijn/haar interactiepatronen. De therapeut tracht niet-veroordelend maar wel doortastend communicatieproblemen in te brengen. 'Eilandjes van gezondheid' worden gebruikt als aanknopingspunt voor de therapie. Wat maakte dat een bepaalde relatie ook als positief werd ervaren, welke aspecten van die relatie waren waardevol? Hoe was de intensiteit van het contact? Hoe kreeg de patiënt wat hij of zij wilde? Vervolgens wordt besproken wat de patiënt verwacht en/of hoopt van toekomstige relaties? Uiteindelijk wordt een plan opgesteld waarin rekening wordt gehouden met de reële beperkingen.

Voorbeeld interpersoonlijk tekort

De patiënt, een 70-jarige man, heeft een sessie voorbij laten gaan en komt nu, na een telefonische uitnodiging van de therapeut, weer naar de therapie. Hij spreekt weinig spontaan en heeft een ontwijkende houding. In eerdere sessies werd duidelijk dat hij zich snel afgewezen voelt en al jarenlang een teruggetrokken bestaan leidt. Toen zijn vrouw nog leefde zorgde zij dat er wel contacten met anderen bleven, maar zij is inmiddels al tien jaar overleden en van hun gezamenlijke contacten is niets meer overgebleven. Patiënt heeft aangegeven erg teleurgesteld te zijn in anderen, inclusief zijn kinderen. Zijn kleinkinderen ziet hij weinig en hij voelt zich als grootvader falen. Nadat deze situatie geëxploreerd werd, werd de vorige sessie gestart met het bespreken van mogelijke oplossingen voor dit probleem.

Therapeut:	*U heeft de vorige afspraak voorbij laten gaan. Was daar een reden voor?*
Patiënt:	*(ontwijkend). Nee, ik was het gewoon vergeten.*
Therapeut:	*Is dat zo, of speelde ook mee dat u op zag tegen het therapie gesprek?*

Patiënt: *(na enige aarzeling) Het hoeft voor mij niet meer, ik ben gekomen omdat u me belde, maar ik geloof er niet in dat deze gesprekken me verder helpen.*

Therapeut: *Na het vorige gesprek had u er dus weinig vertrouwen meer in. In ieder geval goed dat u toch gekomen bent zodat wij dit kunnen bespreken. Had het te maken met wat er besproken is de vorige keer?*

Patiënt: *We hadden het over mijn zoon en zijn kinderen. U liet me duidelijk merken dat ik niets waard ben als grootvader. Daardoor ging ik beroerder weg dan toen ik kwam.*

Therapeut: *Ik kan me voorstellen dat u er daardoor tegen opzag om een volgende keer te komen.*
Ik heb niet willen zeggen dat u geen goede grootvader bent. Waaruit leidde u af dat ik u afkeurde?

Patiënt: *Ik zag het gewoon aan hoe u keek.*

Therapeut: *Tja, wat kan ik daar tegenin brengen? Kan u het nu van mij aannemen als ik zeg dat dat niet mijn bedoeling was?*

Patiënt *Misschien valt het mee.*

Therapeut *Het ging erom dat u momenteel geen kans krijgt om een grootvader te zijn en we spraken erover hoe dat kan veranderen. Kan het zijn dat hier met mij gebeurde waar u eerder over vertelde, dat u snel het gevoel heeft dat mensen u afkeuren?*

Patiënt: *Ja, maar ik dacht het ook echt. Ik had er geen zin meer in en wilde niet meer terugkomen.*

Therapeut: *Maar u bent na mijn telefoontje toch weer gekomen. Dat is een goede stap, want misschien kunnen we het misverstand, door er over te spreken recht zetten. Wat denkt u?*

Patiënt: *Misschien.*

(De therapeut gaat hierop door tot de weerstand afneemt)

Therapeut: *Wat vindt u ervan om dit zo te bespreken?*

Patiënt: *Ik heb er nu wel weer wat vertrouwen in.*

Therapeut *Mooi dat u merkt dat het een gunstig effect kan hebben om dergelijke dingen uit te spreken. Nadat u zich door mij niet begrepen voelde kreeg uw weer meer depressieve klachten. Dat illustreert eigenlijk weer hoe u er letterlijk ziek van wordt als uw contacten met anderen niet goed verlopen.*

Patiënt: *(knikt)*

Therapeut: *Denkt u dat het u nu lukt om verder te gaan en te kijken wat*

er kan veranderen zodat u zich minder beroerd voelt?
Patiënt: We kunnen zien..

Door een relatie te leggen tussen het (slecht lopen of ontbreken van) sociale contacten en de ziekte depressie, kan de ziekte als een hefboom worden gebruikt om veranderingen in de gewenste richting te krijgen: 'hiervan wordt u ziek. In het belang van uw gezondheid moeten er een aantal dingen in uw leven veranderen. Hoe moeilijk dat ook is." De patiënt wordt gestimuleerd om, in eerste instantie heel bescheiden, veranderingen in zijn leven uit te proberen. Vrijwel elke actie van de patiënt wordt aangemoedigd. Wel dient de therapeut er voor te waken dat realistische doelen worden nagestreefd. Ook hier geldt dat als er iets niet lukt, dit benoemd wordt als iets om van te leren eerder dan een signaal van falen.

Vervolg voorbeeld interpersoonlijk tekort:

Het lukte om geleidelijk verder naar oplossingen te zoeken. Zo werd ingegaan op welke manier een contact met zijn zoon kans van slagen zou kunnen hebben. Al explorerend blijkt dat het meest haalbare een laagfrequent contact met de zoon is. Uiteindelijk wordt afgesproken dat patiënt één keer per twee weken samen met zijn zoon naar het voetballen van de kleinzoon gaat kijken.

Ook bij deze problematiek kan gebruik gemaakt worden van rollenspelen. Er wordt vanuit gegaan dat bepaalde patronen niet te veranderen zijn. Dus als iemand erg rigide is wordt dit als gegeven gezien. "U bent erg vasthoudend en precies. Dat is een eigenschap die gemaakt heeft dat u in uw werk goed gepresteerd heeft. Anderzijds is het tot op heden vaak moeilijk voor u dat andere mensen andere maatstaven hebben ". Een steunende en begrijpende houding ten aanzien van dit soort hinderlijke karaktertrekken heeft vaak een positieve invloed op het therapieproces. Meer dan bij de andere focussen is een dergelijke houding noodzakelijk, omdat de patiënten die met dit focus behandeld worden in het algemeen minder frustratietolerantie hebben en weinig zelfvertrouwen.

3.3 Afsluiten van de behandeling

De laatste sessies zijn voor alle vier de focussen in principe gelijk en worden daarom in één keer behandeld. Omdat IPT een kortdurende behandeling is

waarbij de nadruk ligt op veranderingen in het dagelijks leven van de patiënt en in principe niet op de therapeutische relatie, wordt de beëindiging van de therapie als vanzelfsprekend benaderd. De therapeut heeft de patiënt aan het begin en tijdens het verloop va de behandeling ook regelmatig geattendeerd op het tijdelijke karakter van de therapie. Tijdens deze fase wordt de nadruk gelegd op de vorderingen die gemaakt zijn. Er wordt ingegaan op het beëindigen van het samenwerkingsverband en wat dit oproept. Voorts wordt benadrukt wat de patiënt geleerd heeft en vooral wat hij of zij zelf heeft bijgedragen aan het herstel. Als verdere behandeling noodzakelijk is of de kans op terugval groot, wordt dat aan de orde gesteld. Er wordt besproken hoe symptomen van een depressie in een vroeg stadium gesignaleerd kunnen worden en welke stappen de patiënt dan kan ondernemen. Vooral indien er sprake is van recidiverende depressies moeten afspraken over een onderhoudsbehandeling gemaakt te worden. Zoals bekend is de kans op een recidiefdepressie groot. Na één depressieve episode is de kans op een recidief 50%, oplopend tot 90% na drie of meer doorgemaakte depressieve episoden. IPT beschermt onvoldoende tegen het optreden van een recidief (Reynolds et al., 1999; Shea et al., 1992). Het kan nuttig zijn de onderhoudsbehandeling IPT, al dan niet in combinatie met medicatie, aan te bieden (IPT-maintentance; Spanier & Frank, 1998). Het is belangrijk de eventuele noodzaak van een vervolgbehandeling in te schatten. Wanneer een patiënt ook tijdens de laatste afspraak onvoldoende verbetering vertoont, moet een andere behandeling worden voorgesteld bijvoorbeeld een medicamenteuze behandeling of een langerdurende behandeling gericht op persoonlijkheidsproblematiek

Therapeutische houding en technieken:
Bij IPT worden technieken uit verschillende therapierichtingen gebruikt. In de onderstaande opsomming is de aanpassing voor ouderen verwerkt.

- Van de therapeut wordt een steunende, actieve houding verwacht. Dit is in de meeste gevallen waarborg voor het tot stand komen van een positieve werkrelatie.
- Non-directieve exploratie is een belangrijke techniek bij IPT. Bij ouderen is echter meestal een meer directieve houding, zeker in het begin van de therapie, noodzakelijk. Gericht vragen stellen naar interpersoonlijke contacten maakt duidelijk wat de bedoeling is en wat belangrijk is voor de therapie. Het gebruik maken van stiltes in het gesprek wordt bij ouderen afgeraden. Het kan geïnterpreteerd worden als een gebrek aan belangstelling of afwijzing.
- Directieve technieken zijn belangrijk. Ouderen hebben vaak een beperkt netwerk en behoefte aan steun bij praktische problemen (vervoer, huisvesting,

financiën). De therapeut tracht samen met de patiënt een onderscheid te maken tussen praktische problemen die de patiënt zelf kan oplossen en problemen waarvoor steun van anderen noodzakelijk is. De therapeut legt eventueel zelf contact met anderen om het oplossen van een probleem te faciliteren. Ook kan een therapeut gerichte adviezen geven over hoe de patiënt zijn/haar sociale netwerk kan uitbreiden.

- De therapeut wordt binnen IPT geacht nadrukkelijk in te gaan op het affect (de emotionele reacties). Hierbij gaat het zowel om gevoelens die tijdens de sessies naar voren komen, alsook om gevoelens die patiënten in bepaalde situaties hadden. Bij ouderen moet hiermee mogelijk wat voorzichtiger worden omgegaan. Ervaringen van Frank e.a. (1993) waren dat depressieve ouderen vaker heftige negatief gekleurde affecten hadden die ze moeilijk onder controle konden houden. Stimuleren van deze affecten werkte contraproductief. Bij deze patiënten is het doel om hen op een steunende manier te leren hun emoties te reguleren. Bij geremde patiënten geldt deze restrictie niet en moet er, zoals altijd binnen IPT juist gezocht worden naar onderwerpen die gevoel oproepen. Deze worden als uitgangspunt genomen voor nadere exploratie.
- In de interpersoonlijke context is het analyseren van communicatiepatronen een onderdeel van de therapie. Op basis van deze analyses wordt de patiënt aangemoedigd met andere manieren van communiceren te oefenen.
- Door middel van verschillende clarificatietechnieken tracht de therapeut het verhaal van de patiënt te verduidelijken. Zo kan de therapeut in andere woorden samenvatten wat de patiënt vertelt. Ook kunnen tegenstrijdigheden en bepaalde (extreme) standpunten nog eens expliciet aan de patiënt worden voorgelegd. Doel is dat er gedetailleerde, reële beschrijvingen ontstaan van concrete situaties met bijpassende emotionele reacties.
- De therapeutische relatie wordt in principe buiten beschouwing gelaten. Positieve overdracht wordt niet geïnterpreteerd. Daarom kunnen bijvoorbeeld kleine attenties van patiënten geaccepteerd worden. Vooral bij ouderen heeft het vermogen iets te kunnen maken of kopen een positief effect op het zelfgevoel. Het is contraproductief hen dit te ontnemen door een duiding te doen. Soms kunnen overdrachtsfenomenen zodanig interfererend werken op de therapie dat hierop ingaan noodzakelijk is. Dit is binnen IPT echter een uitzonderlijke situatie.
- De therapeut moet in staat zijn om te gaan met eigen gevoelens ten aanzien van oudere patiënten. Ouderen kunnen specifieke gevoelens oproepen bij meestal jongere therapeuten. Deze kunnen een negatieve invloed hebben op het therapeutisch proces. Zo kan de therapeut zich geremd voelen, omdat de

patiënt van de generatie van de eigen ouders of grootouders is. Ook kan angst voor eigen ouderdom of ziekte bepalen dat de therapeut meegaat in de hopeloosheid van de patiënt.
- Confrontatie is ook bij ouderen een goed toepasbare techniek. Het is echter niet de bedoeling de therapeutische relatie te veel op de proef te stellen.

Afsluitend

Deze handleiding is bedoeld ter ondersteuning bij een twee-of driedaagse IPT cursus. Om zich de IPT werkwijze eigen te maken is het verder van belang over een tweetal therapieën supervisie te krijgen. Momenteel is de Comprehensive Guide to Interpersonal Psychotherapy (Weissman et al., 2000) het meest geëigende naslagwerk. Daarnaast is er recent een op de klinische praktijk gericht boek over IPT verschenen dat voor enigszins gevorderde IPT therapeuten erg nuttig is (Stuart & Robertson, 2003).

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Curriculum vitae

Anneke van Schaik werd op 17 februari 1959 geboren in Yerseke, Zeeland. In 1977 behaalde zij het Gymnasium-ß diploma aan het Christelijk Lyceum voor Zeeland te Goes. In de periode van 1977 tot 1984 voltooide zij de studie Geneeskunde aan de Rijks Universiteit Utrecht. Na een tweetal jaren gewerkt te hebben als arts-assistent psychiatrie in het Provinciaal Ziekenhuis te Santpoort, startte zij in 1987 de opleiding tot psychiater in de Valeriuskliniek te Amsterdam, opleider W. van Tilburg. In 1991 werd zij geregistreerd als psychiater en een jaar later als kinder-en jeugdpsychiater. Van I992 tot 1994 werkte zij op de jeugdafdeling van de RIAGG Zuid/Nieuw West in Amsterdam. In 1994 keerde zij, aangetrokken door het academische klimaat, terug naar de polikliniek van de Valeriuskliniek, nu GGZ Buitenamstel. Vanaf die tijd is zij werkzaam als psychiater met aandachtsgebieden stemmings-en persoonlijkheidsstoornissen en ADHD. Zij is tevens coördinator van het co-assistentenonderwijs Psychiatrie van het VUmc en als supervisor van arts-assistenten betrokken bij de opleiding tot psychiater. Daarnaast participeert zij in het onderwijs aan medisch studenten en is vanaf januari 2006 coördinator van het Blok Psychiatrie binnen het nieuwe curriculum van de Geneeskunde studie van het Vumc. In januari 2000 startte zij als junior onderzoeker met het project beschreven in dit proefschrift. In 2006 starten er twee onderzoeksprojecten waar zij als senior-onderzoeker bij betrokken zal zijn, een project naar de effectiviteit van Cognitive Behavioral Analysis System of Psychotherapy bij chronisch depressieve ambulante patienten en, opnieuw in samenwerking met de Afdeling Huisartsgeneeskunde van het EMGO Instituut, een project naar preventie van depressie bij ouderen in het verzorgingstehuis.

Zij woont samen met Hansje Heller, zij hebben drie kinderen.

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Dankwoord
Een onderzoeksproject organiseren en het schrijven van een proefschrift is geen sinecure. Het was dan ook zeker niet haalbaar geweest zonder een uitgebreid "interpersoonlijk netwerk". Om binnen de kaders van de interpersoonlijke psychotherapie te blijven: "Wie waren de belangrijke anderen?".

Het begon zeven jaar geleden toen we met een aantal collega psychiaters/vriendinnen een intervisiegroepje startten. Inmiddels hadden we allemaal een aantal jaren klinische ervaring en we wilden onder andere bespreken hoe we ons werk verder wilden invullen. Ik gaf toen aan dat ik mogelijk wetenschappelijk onderzoek wilde gaan doen. In de jaren die volgden kristalliseerden mijn plannen zich uit, het werd inderdaad een promotietraject. Annemiek, Arda, Merle en Abdoeline, dank voor de inspirerende intervisiebijeenkomsten!

In januari 2000 startte ik op de Afdeling Huisartsgeneeskunde van het EMGO Instituut, heel verfrissend ineens tussen jonge, enthousiaste onderzoekers en zelf ook weer een beetje student. Eerst moesten we het project opstarten en therapeuten, huisartsen en patienten werven. De GGZ instellingen die uiteindelijk deelnamen waren: de GGZ Buitenamstel, de RIAGG West Friesland, het Van Foreest Centrum en De Geestgronden. De participerende huisartsenpraktijken waren in Amsterdam: De Grote Rivieren, Huisartsenpraktijk Hirschfeld en Meyman, Gezondheidscentrum de Vaart, Gezondheidscentrum Osdorp de Punt; in Amstelveen: Huisartsenpraktijk Tholenseweg; in Heiloo: Huisarts Willeboordse en Huisartsenpraktijk Duif; in Zwaag: Huisartsenpraktijk Bangaerde en Gezondheidscentrum Risdam; in Hoorn: Velius' hoed en in Uithoorn: Huisarts Bots en Huisarts Lubbers. Ik wil hierbij de vertegenwoordigers van de vier GGZ-instellingen en de huisartsen danken voor hun bereidheid zich te committeren aan het project. Via de huisartsenpraktijken hebben we de patiënten benaderd. Het was een genoegen te merken dat de meesten van hen zeer bereidwillig waren de vragenlijsten in te vullen en zo een bijdrage te leveren aan het onderzoek.

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Lieve Hannah. Jij bent nu bijna 4, een leeftijd die je erg graag wilt bereiken, want je wilt naar school. Naarmate je groter werd nam je er steeds minder genoegen mee dat ik me terugtrok om te werken. "Ik wil ook werken!" was je reactie de laatste tijd. Hoe dan ook, werk of geen werk, jouw aanwezigheid is een feest voor mij!

Lieve Vita, aan jou is dit alles nog voorbij gegaan. Jij bent nu bijna een half jaar. Jouw lieve lach doet alles relativeren!

Lieve Hansje, vriendin en grote liefde. Wat hebben wij in de afgelopen tien jaar fantastische dingen meegemaakt! Jij hebt me geholpen grenzen te verleggen: we hebben gereisd, kinderen gekregen en een heerlijk familieleven gecreëerd. Jij moedigde me aan onderzoek te gaan doen, waar ik nu ook de rust voor had. Het was wel eens schipperen tussen strijdige belangen, maar in tijden van hoge werkdruk gaf je me de ruimte. Heel veel dank daarvoor. Ik ga niet zeggen dat het nu rustiger wordt, want als dat op het ene gebied al zo zou zijn dan zoeken we wel weer iets op het andere. Dat geldt gelukkig zowel voor jou als voor mij. Daar varen wij nu eenmaal wel bij. Ik vertrouw erop dat we de wind in de zeilen blijven houden!